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ABSTRACT

Presented are reports of individual site visits and results of questionnaires describing nine child abuse and child neglect health-based programs located in Chicago, Denver, El Paso, Honolulu, Iowa City, Los Angeles, New York, Pittsburgh, and St. Paul. Included is information on funding, patient statistics, composition of teams, patient flow, cost of care, community resources, and treatment and rehabilitation services. Among similarities noted among programs are that all use a multidisciplinary approach, all offer medical and surgical care, and most have written guidelines for diagnosis and procedure. Also pointed out are areas of difference among programs such as in the pattern of intake sources, the role of nurses, and relationships with the legal profession. Summarized are overall impressions and conclusions of site visitors such as that a child abuse team cannot deal effectively with a community larger than half a million people and that major federal investments are needed in child abuse treatment and prevention. (LS)

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A DESCRIPTIVE STUDY
OF NINE HEALTH-BASED PROGRAMS
IN CHILD ABUSE AND NEGLECT

April 1974

This study was conducted by a special Task Force of the Committee on Infant and Preschool Child, American Academy of Pediatrics, under Contract HRA 106-74-9 with the Health Resources Administration.

AMERICAN ACADEMY OF PEDIATRICS
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I. INTRODUCTION

Child abuse and neglect are as old as recorded history. Infanticide, the ultimate in abuse or neglect, was sanctioned in many cultures as a means of population control. Inflicted injury has been used not only to drive out evil spirits and to please certain gods, but also to maintain discipline and to inculcate ideas.[1] More recently, at least in Western society, deliberate, severe maltreatment of children has been tabooed. However, only within the last ten years have all of our states had laws encouraging or requiring reporting this practice.

Even with the laws, the true incidence of child abuse and neglect in the United States is not known; reporting is acknowledged to be incomplete. Estimates range from 60,000 seriously abused children a year[2], to 200,000 children a year[3], to 1,500,000 children a year.[4] Studies have indicated that 10% of all trauma seen in children under six brought to emergency rooms is due to suspected abuse.[5]

Dr. Rowine Hayes Brown has written:

> Child abuse victims are of special medical significance because approximately 10% of those hospitalized for their injuries will die. Many others may be left mentally or physically retarded as a result of their injuries, and may ultimately become charges upon our already overcrowded state and private institutions. When one considers the annual cost of keeping a child in such an institution, the economic ramifications of child abuse are evident.[6]

The American Academy of Pediatrics has long recognized that child abuse and neglect is one of the major unsolved health problems of our children. Statements by the Academy's Committee on Infant and Preschool Child in 1966 and 1972, and articles in PEDIATRICS, the Academy's scientific journal, are evidence of the Academy's concern (Appendix A). The Committee is preparing a self-instructional course on the recognition and management of child abuse that will be available to Fellows of the Academy and to the general professional public. It will be helpful to persons who are organizing coordinated community programs.

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[1]Helfer, R.E., and Kempe, C.H., ed.: The Battered Child, Chicago: University of Chicago Press, 1968.

[2]Kempe, C.H., Paper presented to the Harvard Inter-Faculty Seminar on Child Rearing in Urban America, 1972.

[3]Report of the Governor's Committee on Child Abuse, to Francis W. Sargent, Governor, Boston, Massachusetts, October 1971.

[4]Fontana, V.J.: Statement at American Medical Association Annual Meeting, June 1973.

[5]Holter, J.C., and Friedman, S.B. Child Abuse: Early case finding in the emergency department. Pediatrics 42:128, 1968.

[6]Brown, R.H., etal. Medical and Legal Aspects of the Battered Child Syndrome, Chicago-Kent Law Review 50:45, 1973.

The survey of nine health-based child abuse programs that is the subject of this report is another link in the chain that the Academy of Pediatrics is helping to forge to contain this problem. It examines, for the programs visited, the procedures and practices in the context of their communities. It points out their commonalities and differences. However, it is in no way definitive. The sites selected for study were not randomly chosen; moreover, they were exclusively "health-based." The visits were brief. The reports of the visitors were necessarily impressionistic. Nevertheless, inferences can be drawn of the elements which make for a successful program, and of areas which are in need of further development and support.

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II. METHODOLOGY

The American Academy of Pediatrics delegated the survey project to its Committee on Infant and Preschool Child. The Director of the Department of Committees, as Project Officer, and the Chairman of the Committee shared the supervision. The Administrative Assistant to the Council on Child Health was an invaluable member of the supervisory team. As Project Director, an experienced pediatric practitioner who was a former Committee member and consultant was selected, with the concurrence of the Subcommittee on Child Abuse.

The latter group also assisted in assembling a Child Abuse Survey Task Force. Six persons representing a variety of disciplines were invited to join with the Academy's personnel in a planning conference in Evanston, November 16, 1973. All but two attended the day-long meeting, and they participated in subsequent Task Force work either by telephone, by correspondence, or in person. (Appendix B)

With direct input from pediatrics, psychiatry, psychology, public health nursing, social work, sociology and administration, and indirect input from the law, the Task Force developed a protocol for the site visits. A questionnaire was designed to elicit, in an orderly manner, information on the establishment of each program, the population it served, the flow of children into and through it, the disciplines brought into play in the handling of the child and the family, the community inter-relationships, the legal constraints, if posssible some information on costs and sources of funding, and finally the ultimate goals and new projects perceived by the program's personnel. (Appendix C)

The Task Force also considered which nine sites should be visited. The criteria were:

the programs should be health-based;

they should have wide geographic distribution;

they should serve a variety of populations;

they should employ a multidisciplinary approach;

they should have been in operation long enough to provide descriptive information.

The contracting agency was consulted and had concurrence in the final selection. The programs chosen were:

1. Chicago, Illinois -- Cook County Children's Hospital.

2. Denver, Colorado -- National Center for Prevention and Treatment of Child Abuse and Neglect.

3. El Paso, Texas -- William Beaumont Army Medical Center.

4. Honolulu, Hawaii -- Children's Protective Services Center, Kauikeolani Children's Hospital.

5. Iowa City, Iowa -- University of Iowa Child Development Clinic.

6. Los Angeles, California -- Children's Hospital of Los Angeles.

7. New York, New York -- New York Foundling Hospital.

8. Pittsburgh, Pennsylvania -- Children's Hospital of Pittsburgh.

9. St. Paul, Minnesota -- Saint Paul-Ramsey County Mental Health Center.

An attempt to locate a child abuse treatment program in the South was unsuccessful. None was known to members of the Task Force. A rapid telephone survey of the Academy's Chapter Chairmen throughout the South, and the members of Departments of Pediatrics in southern medical schools was also unproductive. Similarly, no Indian program is listed; no health-based child abuse program treating Indians could be found.

The Project Director wrote to each program director, explaining the nature and purpose of the survey. All were cooperative, even eager to participate. A date for a one-day site visit was then set for each program, and the questionnaire mailed in advance, so that it could be completed by the program's staff prior to the visit.

The cooperative spirit noted above was manifested throughout each of the visits. Personnel in each program shared their experiences, their successes and failures, their hopes and despairs, their goals and obstacles with the visitors. It was not possible to have the same team visit all of the sites. The Project Director and the Administrative Assistant did. They were joined at each visit by one or more members of the Task Force. Because of this variation in the visiting teams, site visit reports may reflect the backgrounds and interests of the visitors, and the emphasis may vary from one program to another. However, it must be stressed again that this project is impressionistic; that there are very little hard data to be had. Accordingly, while observer variability should be noted, it does not discredit the report.

At some time during each visit the "completed" questionnaire, which was generally incomplete, was reviewed with the program director and/or other members of the staff. It sometimes took a fair amount of probing to get all of the answers possible.

Some questions could not be answered, most frequently in relation to costs and resources. There is no uniform system, sometimes no system, for keeping records or tabulating results. Nevertheless, the review procedure proved to be an essential element of the visit. It served to strengthen the comparability of observations.

The finally completed questionnaires and site visitors' comments were duplicated and shared with the entire Task Force and with the Subcommittee on Child Abuse as soon after the visits as possible. After the field work had ended, the Project Director wrote a preliminary draft report which was distributed to the same two groups. Copies of Parts IV and V were also sent to the entire Committee on Infant and Preschool Child. The Committee convened for an all-day discussion of the survey and the report on February 28, 1974. The Task Force did so on March 12, 1974. Based on critiques from those two workshop sessions, this final report was written and is submitted in compliance with the contract. It has not had a detailed final review from the two groups.

III. REPORT OF INDIVIDUAL SITE VISITS

This section contains a narrative description of each of the nine programs visited by members of the Task Force. These descriptions are intended to convey pictures of the main features of the programs, the context in which they operate, and a feeling for the morale and working philosophies of the team members.

The narratives are to some extent, and necessarily, impressionistic. The visiting team spent only one day at each site, and their report conveys a broad-stroke picture rather than a comprehensive and exhaustive tabulation of the characteristics of each program.

Although comparisons of programs are not valid, some inferences have been drawn in Sections IV and V.

SITE VISIT NO. 1

Cook County Children's Hospital
Chicago, Illinois
January 10, 1974

Cook County has a population of 8 million. It includes and surrounds Chicago, population 3.5 million. The Cook County Hospital serves, essentially, the poor of southwest Chicago and Cook County, an area of inner urban poverty with a changing ethnic population, 90% black and decreasing, 1% Spanish-American and increasing, and white. The Cook County Hospital is used by the surrounding community as its family hospital. All the patients are poor. The outpatient clinic is free to all, but the hospital has a fixed flat fee of $171 per day covering all services, regardless of age or diagnosis. Ability to pay is not a criterion for admission to the hospital.

Under Dr. Rowine Hayes Brown, medical director and former chief of pediatrics, the hospital has pioneered the diagnosis and treatment of child abuse in the Chicago area, and a high level of concern for child abuse is maintained by the current chief of service, Dr. Robert A. Miller, and the head of the social service department, Mrs. Helen Jaffe, M.S.W. The child abuse program at Cook County Children's Hospital is carried out through medical treatment of the patient. The hospital sees its first responsibility as protection of the abused child. The child abuse cases seen are largely severe, 60% brought in by the police, 100% through the emergency room. No cases are private physician referred. One hundred and fifty cases are diagnosed a year out of an outpatient flow of 150,000. Fifty abused or neglected children are hospitalized a year at Cook County, a small portion of those seen and suspected. About 10% of the cases are neglected, rather than physically abused. Cook County has more sexually abused than battered children. Two hundred cases of sexual abuse are seen yearly, more than twice the number recorded at any of the other sites visited. Only one or two of these are admitted. One thousand abused children were seen at the hospital in the last five years. The 50 cases hospitalized annually therefore represent only the tip of the iceberg; other cases are treated in the outpatient clinic. Those admitted to the hospital are treated and medical follow-up given where indicated (surgery for broken bones, skin grafts, etc.). The average stay is 2-4 days, but some children have had to remain in the hospital as long as 7 months for medical treatment. The abused children hospitalized are drawn from the community around the hospital and follow its demography.

Illinois has a state protective agency, the Department of Children and Family Services (CFS), directed by Dr. Jerome Miller.

Cook County Children's Hospital

The Illinois Abused Child Act requires that all cases of abuse -- both diagnosed and suspected -- be reported to the Illinois Department of CFS. When this happens, CFS takes over the investigative and dispositional aspects of the case; and except in the rare instances where a physician's testimony is requested in court hearings, there is no provision for feedback from CFS to the hospital. CFS maintains a 24-hour phone for reporting, but its operation is erratic. Dr. Robert Offutt is the director of the District Office of CFS. His staff of 114 serves the population of Cook County, including 63 hospitals reporting child abuse and neglect. The rapport between Cook County Children's Hospital and CFS is variously reported as "excellent" to "non-existent." There is, however, agreement that problems occur, particularly in follow-up, because the CFS' staff is overworked and undermanned.

The Child Abuse Team at Cook County Children's Hospital is headed by a pediatrician and consists of one attending physician, the resident physicians in pediatrics and surgery, three social workers, the hospital administrator, two psychologists, a psychiatrist, and a nurse assigned full time to the psychiatric team. The team had met informally for some time, and has just begun to meet on a weekly, scheduled basis. A protective service representative is not regularly present at meetings of the Child Abuse Team.

The child abuse treatment is entirely crisis-oriented. Medical and social rehabilitative services are available and used. Social and psychological follow-up (i.e., beyond evaluation) is almost non-existent.

Dr. Brown has developed child abuse guidelines which are utilized by emergency room personnel, social worker, and other departments in identification and reporting. These guidelines are strictly observed. They are as follows:

PROCEDURES FOR
ABUSED, ABANDONED, & NEGLECTED CHILDREN
(ALL AGES)

I. Battered Child Syndrome

Upon admission, the child is automatically referred by the ward physician to Dr. Brown. After examination, they concur and Dr. Brown submits a written report to Illinois Children & Family Services to report the battered child within 24 hours. This agency is then responsible for the investigation of the home situation and submits a report within ten days to Springfield, and keeps Social Service informed of status of case.

Our Social Service Department places an automatic hold on all battered babies pending an interview with the parents and a subsequent report from Illinois Children & Family Services as to what

disposition and plans should be made for the child in question. In our interview, we attempt to ascertain who is responsible for the child' s condition and what were the circumstances causing the child's abuse. After all social information is obtained, a green sheet should be typed and submitted to Dr. Brown indicating briefly the home situation and future plans for the patient. Case records are made on all battered babies.

II. Abandoned Children

These cases are referred to the Emergency Protective Service Unit of the Department of Children & Family Services, 341-8502. If the Abandonment Unit of the Chicago Police Department are not involved, they should also be contacted.

Both the agencies coordinate activities to handle the situation.

III. Neglected Children

These cases can be referred to the above agency or Social Service can file a neglect petition through Juvenile Court. Referrals are made to:

Mr. Leonard Goodman
Deputy Chief & Probation Officer
Complaint Department of Juvenile Court
2246 West Roosevelt Road
Chicago, Illinois 60608

The abuse team maintains a hospital registry in addition to the state registry in Springfield, which apparently does not work well. There are plans for a central registry for all Chicago. At present, access to the state registry in Springfield is available only through a CFS social worker who must be reached and persuaded to check the registry; this is impractical for hospital staff.

The hospital social service work is effective. Under the state law, child abuse and neglect are somewhat different categories. The hospital is required to report abused and neglected children, but is reluctant to report suspected neglect. When cases are reported, CFS takes over and follows through with child and family to ultimate disposition. Cases not actually reported can be followed up by the hospital, and there is coordination with the Visiting Nurse Association through the Home Care program.

CFS has 47 follow-up social service workers for the city of Chicago; in addition, there are Emergency Protective Service workers for emergency cases. Child abuse cases are seen by CFS on an average of two to seven times. These workers are not part of the Child Abuse Team; they do not attend conferences. The work of the Department of CFS in child abuse in Chicago is dispositional, not preventive

or therapeutic. Case workers are assigned to a case by their supervisor. They make an on-site visit within 24 hours. Most cases go to court within 36 hours after the assessment of abuse is made, if the hospital wants to hold the child or if the police have taken physical custody. Parents of the neglected or abused child have the option to allow the child to be placed out of home voluntarily. This placement is only for 90 days. Parents who refuse foster care placement usually go to court. Less than half or as few as 30% of reported child abuse cases in Chicago go to court.

When a worker decides to file a case in court, there are at present four attorneys available to the city protective services. There are usually two court hearings. After the first hearing, the case is reassigned by CFS to a different court. Final decision as to whether the home is "safe" for the child's return is made by the judge in juvenile court on the basis of the age of the child, the recommendation of the social worker, and perhaps medical evaluation of the child and family. If the decision is to send the child to a foster home, there is the problem of the lack of good quality foster homes. Placements for handicapped or older children are especially difficult.

CFS has responsibility for follow-up and rehabilitation. However, this area is weak. There are recognized needs for facilities for teenagers, for psychotherapy for suspected or high-risk cases of child abuse, to keep them from becoming acute; and for counseling to develop a clear relationship between the foster and natural parents. CFS does not inform the hospital Child Abuse Team of disposition of the child.

The hospital Child Abuse Team has been active in promoting understanding of the child abuse problem. Dr. Brown has lectured before medical meetings, law groups and community groups. Mrs. Jaffe, the hospital Social Service worker, has also spoken before lay groups as well as directors of social service programs in hospitals. Media exposure -- newspapers, television, radio -- has been widespread but emphasizes the sensational aspects of child abuse. The hospital team recognizes the higher incidence of abuse in prematures, and has instituted a parent education program for parents of premature infants; they are encouraged to come in and hold the baby so they have some feeling of mothering and better acceptance when the infant is sent home. The hospital plans to start working with the mother from the time of birth and the same social worker will follow the family after discharge, and also when the child goes to the clinic.

At the district level, Dr. Offutt is planning an education program for the community, including the suburbs, on neglected children. His office will have a team to deal with runaways and teenagers who need help.

CFS does some instruction of police who work with child abuse; there is an effort to relieve pressure on the adult so that he is not arrested.

SUMMARY

The Cook County Children's Hospital child abuse program is essentially an in-patient, short-term program. Long-term follow-up, except for medical treatment for fractures, burns, etc., is not feasible under the present program. The hospital is not informed of follow-up and disposition of cases, and does not undertake rehabilitative work with the family. The child abuse treatment, therefore, is entirely crisis-oriented. Medical and physical rehabilitative services are available and used. Social and psychological follow-up is almost non-existent; it is not provided by the Department of Children and Family Services, nor does CFS use the hospital services or the services of available public health nurses. It appears that cases of abuse in the Cook County area are, following reporting to protective services, either put in foster home care for an unknown length of time, or their parental rights are terminated, or the case is returned home, or the case is closed.

Supportive community services are few and inadequate. At present, Cook County does not adequately prevent, treat, follow up, or rehabilitate its abusing and neglecting families.

Additional information on file at the Academy office:

1. Questionnaire.

2. Site visit reports by individual team members: Dr. Bates, Ms. Caulfield, Ms. Pambrun, Ms. Tenne.

3. A study of patients seen in the admitting area of Cook County Hospital, by Phillips, C.W., Boswell, J., and Jaffe, H. Unpublished.

4. Child abuse by burning, by Stone, N.H., Rinaldo, L., Humphrey, C.R., and Brown, R.H. Unpublished.

5. The Battered Child, by Brown, R.H. Reprint from Chicago Medicine, March 24, 1973.

6. Medical and Legal Aspects of the Battered Child Syndrome. Brown, R.H., Fox, E.S., and Hubbard, E.L. Reprinted from Chicago-Kent Law Review, Vol. 50, Summer 1973, No. 1.

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Date & basis for establishment of CA/N program	
Location	Hosp.
AUSPICES: Hospital, Medical School, Health Dept., other (explain)	Hosp.
Medical School affiliation	Yes
FUNDING: Grant (type), public, private, state institution, other	County
Allotments if any for CA/N	None
Funding restraints	-
Copy of budget attached	No
PATIENT STATISTICS	
# inpatients/year	12,000
# outpatients/year	120,000
# abused patients admitted/year	50
# abused patients treated in outpt dept/year	100
# sexually abused/year	202
# neglected/year	10%
CA/N TEAM	
Composition & % of time in CA/N	
Head — Pediatrician*	1 to 5%
Coordinator — Social worker	10%
Hospital Administrator	1 to 5%
Pediatrician — Three	1 to 5%
Physician — Resident	1 to 5%
Surgeon — Resident	1 to 5%
Nurse	15 -20%
Social Worker — Two f.t.	100%
Attorney *	1 to 5%
Other (state) (2) Psychol. 5-10% (1) Psychiat.	15-20%
Does Team see all suspected cases of abuse?	Yes
" " " " " neglect?	No
Are there written, procedural guidelines for Team?	Yes
Who developed them?	Team
PATIENT FLOW	
Intake — % through Emergency Room	100
% through Pediatric Clinics & Wards	Na
% through Child Welfare Social Service	< 1
% through neighbor report	< 1
% through private physician	0
% through parental call for help	0
% through police	60%
% through school	0
% (other state)	0
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological history?	Yes
Family profile? (Information on subs and parents)	Yes
DIAGNOSIS - IDENTIFICATION	
By CA/N team according to established criteria	Team
By individual physician or EM staff	
Previously identified and sent to center for confirmation and treatment	
TREATMENT	
24 hr medical/surgical treatment available	Yes
Psychological service	Available
EVALUATION of child	
for emotional disabilities	Avail-
for learning disabilities	able,
for physical disabilities	not
Evaluation of PARENTS?	routine
Evaluation of SIBLINGS?	for ev-
	ery case
REHABILITATION	
Medical/Surgical	Yes
Psychological	Avail.
Short term rehabilitation	Yes
Long term rehabilitation	No
Referral to other treatment center	CFS
If rehab appointments are not kept, is there follow up and by whom?	Hosp. S.W.
COST OF PATIENT CARE	Inpatient
Delineated for Treatment, Evaluation, Rehabilitation	$172/day
FOLLOW UP	
Is there feedback to program from Protective Services?	No
CASE CONFERENCES - in facility	
Held regularly, weekly or monthly	Monthly
All members of team attend	Yes
Conference on special call	Yes
Professionals from community attend?	Sometimes

COMMUNITY CHARACTERISTICS	
Boundaries for population surrounding health facility	See
Economic class	text
Ethnic composition	
POPULATION SERVED BY PROGRAM	
All from surrounding community	
Economic status	See
Ethnic composition	text
Patient population not selected by center	
Special category	
COMMUNITY RESOURCES	
Day Care Center/24 Hours	No
Crisis Nursery	No
Foster Home	Yes
Therapeutic foster home	No
Hotline	Yes
Parent Aides	Yes
Parents Anonymous or other self-help group	Yes
Homemaker	Yes
Other, as Public Health Nurse	Yes
If available, would you use all or most of these?	
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	No
Does it relate with hospital team?	
EDUCATION	
in Community - lay public	Yes
in Hospital	Yes
School of Medicine, Law, Nursing	Yes
Public schools	Yes
Police Department	No
Other (state)	Health Advocates
PROTECTIVE SERVICES	
Hospital and Community cooperate	+
Can child be held without parents' consent?	Yes
CRITERIA for considering home "safe" developed with hospital participation	No
REPORTING mandated?	Yes
Abuse reports - by Team or individual? Team dec.	M.D.
Report sent to:	CFS
Investigated by:	CFS
Neglect reports - by Team or individual? Team dec.	M.D.
Report sent to:	CFS.
Investigated by:	CFS
Reporting procedure weekends, holidays, 24 hours?	Poor
Parents informed of reporting?	Yes
REGISTRY - in hospital	Yes
Central registry in state or community	Yes
Is central registry effective?	No
Can it be used by CA/N team?	No
Can complaint be expunged from record?	By CFS
DISPOSITION	
Joint decision by team and protective service	No
Conference with family before disposition hearing	Unknown,
% returned home	CFS
% returned home under protective custody	juris-
% referred to Foster Care	diction
% termination of parental rights	
Any team members involved in court hearings?	Occasionally
GUIDELINES AND CRITERIA	
for Abuse - written? unwritten, flexible on individual basis	Written, flexible
for Neglect - written? unwritten, flexible on individual basis	Written, flexible
Established criteria for considering home "safe"	By CFS
PROFILE OF ABUSER: Parents, paramour,	adult rel.
Alcohol a factor in abuse	Yes
Drugs a factor in abuse	Rarely
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	Yes
Surveillance of newborns in abusive family?	Yes
Observations by obstetrical nurses	No
Identification of "high risk" mothers in prenatal clinics?	No
FAMILY COUNSELING?	
Family planning recommended?	Sometimes
RESEARCH - ongoing	Yes
New study or expansion of research planned	Profile

SITE VISIT NO. 2

University of Colorado Medical Center
Denver, Colorado
December 18, 1973

The Colorado General Hospital is a state supported hospital which serves as a treatment facility for the city and state, and teaching facility for the University of Colorado School of Medicine and Nursing. It has a child abuse treatment program funded by an on-the-line item in the state budget. The Hospital is the acute care center which admits and provides initial study and treatment for cases of child abuse. There are 44,000 visits to the pediatric outpatient department of Colorado General Hospital annually; there were 2,192 pediatric admissions to the Hospital in the last fiscal year.

The National Center for the Prevention and Treatment of Child Abuse and Neglect, established in 1972, is located in an old Salvation Army Home for wayward girls, and constitutes a separate site for follow-up of child abuse, parent meetings, individual and group therapy, and crisis nursery.

Both facilities are used for professional teaching, and the professional staff and the patient load of the two facilities overlap.

The objectives of the National Center are: to provide the professional working in the field of child abuse with the most extensive and up-to-date educational, research and clinical materials available, and to provide an on-going service to families in crisis situations.

Denver is a city of 495,000 population on the western edge of the Great Plains, and is the medical and educational center of the state, population 1,755,000. There are urban slums in Denver and isolated settlements in the mountains behind. The area served by the Center encompasses metropolitan Denver as well as parts of Nebraska and Colorado.

Forty percent of child abuse cases come into the Center through parental calls; 50% come through the emergency room of Colorado General Hospital (again, essentially by parent initiative). Only 10% come in through reports of others. Private physician reports account for about 2% of entrance into the program, police 1%, schools 1%, and other agencies 4%.

The Center treated 126 pediatric patients in 1972. Of these, 25% were abused, 75% neglected, and one sexually abused.

University of Colorado Medical Center

The patient population at Colorado General Hospital is primarily lower and middle class. Most of the child abuse patients who are admitted there are welfare recipients. However, the self-referrals, who come into the Center other than through the Hospital, come from all socio-economic groups. Acknowledgment of child abuse appears to be an "in thing" in Denver, with abusing families developing a social life, like Alcoholics Anonymous, and having middle class characteristics.

The Team

The Child Protection Team originated in the Department of Pediatrics at the University of Colorado under the direction of Dr. C. Henry Kempe in 1958. The Denver model is the principal national one for the multidisciplinary, health-based prevention and treatment of child abuse. It is well known and has provided the model for most pediatricians and many multidisciplinary teams (St. Paul-Ramsey County).

The Denver team has four pediatricians; three psychologists, all part-time; one child developmentalist, three social workers, one part-time; ten lay therapists, two research assistants, two coordinators, two clerks, one public health nurse, one psychiatrist, and one attorney. The team also consults with a radiologist, sometimes a neurologist, and an orthopedic resident.

The Denver group coined the phrase, the "battered child". From Denver, Drs. Kempe, Helfer, and Steele have written definitive works on child abuse. The team is visited daily by students of child abuse. Teaching is individual and practical rather than group and didactic.

Drs. Kempe and Helfer have refined diagnostic procedures in child abuse. In their "Guidelines for Managing Child Abuse and Neglect Cases at Colorado General Hospital", they have spelled out 15 rules in detail. Among these are:

Hospitalize the suspected case;
Elicit detailed facts about the injury;
Obtain Child Protective Team (Child Abuse Team) consultation within 24 hours;
Maintain helpful approach to parents, and tell parents the diagnosis and the need to report it.

All cases of suspected child abuse admitted have a detailed workup with consultation and appropriate reporting within 24 hours. The Team does a complete diagnostic workup of every child with injuries, whether seen in the hospital outpatient clinic or admitted. This includes complete history and physical examination, complete social history, complete psychiatric evaluation, mental status if needed, psychological testing if needed, and home evaluation.

University of Colorado Medical Center

A report is filed on any child who has documented injuries regardless of the family's willingness to cooperate with treatment. Very often children are admitted only when bruises are evident; these children may not need medical treatment, but the case needs reporting and time is required to do the evaluation and arrange treatment. In these situations, the hospital is used as the protective place for the child until a treatment plan can be devised and the Welfare Department can be notified.

The Child Protection Team receives referrals, not only from the Colorado General Hospital, both inpatients and outpatients, but from welfare departments, schools, physicians, and other hospitals throughout the state. There are also a small number of self-referrals.

Cases are worked up at an average total cost of $300. Follow-up medical/surgical treatment may cost from $300 to $10,000, and it is still more difficult to estimate cost of rehabilitation. Medical fees are on a sliding scale, according to the family's income. Insurance or Medicaid often covers the treatment. All social and psychiatric work-up by the Child Protection Team is free. The police are authorized to issue a 48-hour hold which allows the hospital to hold and treat the child without parental consent. Also, custody can be retained against the parents' wishes, through the juvenile court in which the family resides, by the filing of a dependency and neglect petition. In the majority of cases this is filed by the Child Welfare Department.

Dispositional decisions are made on the basis of a multidisciplinary team decision. On discharge, 50% of the children are returned to their own home; 50% go to a foster home. (75% are discharged to protective services.)

The guidelines for managing child abuse and neglect cases at Colorado General Hospital are attached. They include reporting obligations, consultation procedures, and a description of follow-up steps. All reports of abused children go to the police department, the child welfare department, and the central registry which was established in 1972 by state law. The child abuse group at the National Center does not consult the registry.

There is a uniquely close relationship between the staff of the team and the abusers. Except for Louise Soule, the coordinator, team members are involved only part-time in child abuse; or if they are full-time, their responsibility is divided between patient research and patient service so they do not have a full caseload. The work is considered so demanding that it is necessary for staff to have some relief from pressure of these cases. In spite of, perhaps partly because of, the no full-time rule, they "live with" the abusers. The staff has a true social life with the abusing families, sharing each others' homes, lending and being repaid small sums of money (the difference between rich and poor is carfare

when you need it), going to parties together, keeping in touch when they move. The group finds that, though they can prevent physical abuse -- no death in 2-3 years -- they have not changed the parents or the children very much in other ways. Only 25 - 30% of families are considered to have improved their lifestyle.

A unique feature of the National Center is the Crisis Nursery which opened in 1972 as an 8:00 to 5:00 facility. This consists of two rooms with an adjoining bath; one room has a stove and refrigerator; the other has one twin bed and two cribs. At first, the Nursery was staffed with volunteers, who also provided babysitting services to parents to enable them to keep appointments with their therapist, social worker, etc. In October, 1973, the Nursery began offering 24-hour service, still staffed with volunteers in the daytime and supervised by two nurses. The Nursery functions as an "Extended Care Facility" of the University of Colorado Medical Center and Colorado General Hospital, but is located at the National Center. The personnel are carefully chosen, and their observations have proved helpful. Weekly group meetings are held. At the Nursery, parents can stay with their child if they wish, but each child is observed and his individual needs met by the Nursery staff. Children can stay here until they are placed or returned home. Parents are asked to call directly to the Crisis Nursery before coming in with their children. Only children of parents in treatment by a staff therapist or the lay therapists and Families Anonymous groups are eligible to use the Nursery.

Families Anonymous has a 24-hour "hotline", and the Center works with this group. Families Anonymous is directed by a former public health nurse, and supported by the University of Colorado Medical Center Child Protection Team.

Due to the large number of self-referrals and potentially abusive families the Center works with, treatment is often provided on a voluntary basis. In the majority of these cases, the children have no injuries which can be documented.

Public health nurses play an integral role in treatment of abusive families. If a child is in the hospital but will return to the parents' home, a public health nurse is routinely asked to become involved. If a public health nurse is involved in a situation where a child temporarily goes to a foster home, she may be active in helping the family with other children who remain in the home. She may be the primary therapist in cases identified as potential for abuse when the child is born at Colorado General Hospital. Because the public health nurse visits in the home, she sees the family from a different perspective than is possible by the other members of the team.

Lay therapists are also an important part of the program, especially in follow-up. They are carefully screened, and must exhibit strong interest and be willing to make a long-time commitment.

University of Colorado Medical Center

Like other child abuse workers at Denver, they are not allowed to spend more than "half time" with abused children or abusing parents because of the emotional drain involved.

Records are kept on families seen, both those who have been evaluated and those on long-term treatment. A card file is kept in the hospital office containing brief data on all cases. A more complete file is also kept at the hospital on all cases seen for a diagnostic workup. It contains progress notes, conference minutes, social history, copies of psychiatric and other evaluations, a copy of the abuse report, and a current running record on the case. There are similar files at the Center.

The National Center sponsors an annual training seminar; the next one is scheduled for September 30 - October 1, 1974. These are limited in size, but are open to all professionals working in the field of child abuse and neglect. Other, smaller training sessions are held throughout the year with people making their own contacts with the Center. Also, members of the team periodically travel to other parts of Colorado and the United States to participate in training sessions and conferences on child abuse and neglect.

The Center conducts continuing education programs in all graduate schools: the Law School, the Schools of Medicine and Nursing and Public Health, and educational efforts are made through high schools, the police department, civic clubs, the American Humane Society, and the media. During 1973, the Child Abuse Team, or members, participated in conferences in 27 states. Educational conferences and presentations are organized for many groups on request: parent aides, Parents Anonymous, mental health personnel, antenatal classes, public health nurses and lay groups. Some of these efforts involve use of video tapes and other techniques useful in training or rehabilitative efforts. A catalogue of self-instructional material is available from the National Center.

Additional information on file at the Academy office:

1. Questionnaire

2. Site visit reports by individual team members: Dr. Bates, Ms. Elmer, Ms. Pambrun, Dr. Steele, Ms. Tenne.

3. Child Abuse and the Central Registry, by Brian G. Fraser, Staff Attorney, the National Center for the Prevention and Treatment of Child Abuse and Neglect. Unpublished.

4. Presentation of 1973-74 work of Beezley, Conway, and Martin. A study of less seriously injured preschool children to determine the effect of abuse upon their personalities. Unpublished.

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GUIDELINES FOR MANAGING CHILD ABUSE AND NEGLECT CASES AT COLORADO GENERAL HOSPITAL

When a parent or guardian brings a child to the Emergency Room or Child Care Clinic and the physician suspects the child has sustained non-accidental injuries, caloric deprivation, incest, or serious medical care neglect, the following procedure is recommended. Serious homicidal threats (eg. "If I have to spend another minute with that kid, something bad is going to happen.") also require admission.

1. Hospitalize the suspected case: The extent of injuries is not relevant to this requirement. The purpose of hospitalization is to protect the child until other evaluations regarding the safety of the home are complete. The reason given to the parents for hospitalization is that "his injuries need to be watched," or "further studies are needed." It is not helpful to mention the possibility of non-accidental trauma or underfeeding at this particular time. The outpatient physician should keep incriminating questions to a minimum. If it becomes difficult to persuade the parents of the need of admission, contact Drs. Schmitt or Gray (x7961 or x8269) for assistance. If the parents refuse hospitalization, a court hold can be obtained. This is rarely needed and should not be a routine procedure. The case can be safely evaluated while the child remains in the home in a few instances (i.e. the offender was a boyfriend who is in jail or a babysitter who is no longer employed).

2. Treat the child's physical problems: Once the child is in the hospital, the medical and surgical problems should be cared for in the usual manner. An orthopedic consultation is commonly needed. Opthalmologists, neurologists, neurosurgeons, and plastic surgeons are occasionally consulted. The malnourished child needs to be placed on ad lib feedings of a regular diet. Consultation with a nutritionist may be helpful.

3. Obtain necessary laboratory tests: Every suspected case should receive a trauma survey. Avoid using incriminating terms (e.g."rule out battering") on requisitions. Sometimes the x-ray findings change a suspected case into a definite case of non-accidental trauma. If there are bruises or a history of "easy bruising" one should obtain a "bleeding screen," (platelet count, bleeding time, partial thromboplastin time and prothrombin time - call x8471). If there are visible physical findings, color photographs should be obtained before they fade (call x8531). These require a parental consent form or a court order, but the photographer can take them before hand. Children with failure to thrive need very few lab tests unless caloric rehabilitation fails.

4. Elicit detailed facts concerning the injury: A detailed history should be obtained by one physician on the ward as to how the accident allegedly happened (the place, the exact time, the sequence of events, people present, medical attention sought, etc.). The parents can be pressed for exact details if necessary. This history should be obtained as soon after admission as possible, before the parents have had time to change their story. It should be recorded precisely, for other professionals will refer to it rather than resurrecting these issues with the parents. Also, the consent form for pictures should be obtained before the parents leave. A detailed feeding history in caloric deprivation cases is sometimes helpful, but it is not necessary for diagnosis.

5. Obtain C.P.T. pediatric consultation to confirm your diagnosis, within 24 hrs: Some cases are obvious, others are confusing. The stakes are high; physical abuse is a life-threatening disease. A faculty pediatrician should always be consulted first to help the housestaff decide if child abuse has definitely

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occurred. The C.P.T. pediatrician should be called during the initial admission since these parents sometimes don't visit. This is the pediatrician's job; not the psychiatrist's or social worker's. The physicians to call for a pediatric consultation are Drs. Gray, -- Schmitt, Cozzetto or - Kempe (x8269 or x7533). If child abuse has not occurred, steps 6 and 12 need not be taken. The conclusion sometimes reached is that there is not sufficient evidence for child abuse, but that referral to a hospital social worker or a mental health facility is in order.

Indications for C.P.T. pediatric consultation are:

(a) physical abuse (i.e. unexplained or inadequately explained bruises, swellings, fractures, or burns. This should also include any bruises which are inflicted in the name of discipline.)
(b) Failure to thrive secondary to under feeding (as documented by having the infant gain at over 1.5 oz/day while in the hospital on a regular diet, or suspected on admission because of unusual behavior by the mother.)
(c) Sexual abuse (molestation or incest).
(d) Medical care neglect (i.e. noncompliance with therapy or not seeking medical care when the omission is life threatening).
(e) Drug abuse of young children (i.e. caretakers who give children dangerous drugs without a physician's orders).

6. Maintain helping approach to the parents: This is the hardest step. Feeling angry with these parents is natural, but expressing this anger is very damaging to parent cooperation. Confrontation, accusation, and repeated interrogation must be avoided. The primary physician must see or phone these parents daily. They become suspicious quite easily if communication is not optimal. If the child is brought in with multiple life threatening injuries or D.O.A., the parent requires an emergency psychiatric evaluation because he may be psychotic or suicidal.

7. Tell parents the diagnosis and the need to report it: Tell the parents the diagnosis and the need to report it before doing so. Tell them: "this is an unexplained injury" or "your explanation for the injury is insufficient." Then add: "I am obligated by Colorado law to report any injury to any child that is hard to explain." The physician should do this since the case is reported on the basis of his medical findings. He should be willing to discuss the general content of the report. He can add that child welfare will be involved (not the police), that the matter will be kept confidential (not in the newspaper), and that everyone's goal is to help them find better ways of dealing with their child (not to punish them).

8. Report to Child Welfare by phone within 24 hours: The call goes to the agency charged with children's protective services in the patient's county of residence. The C.P.T. coordinator (Ms. Louise Soule) will place this call if the physician wishes her to.

9. Complete an official written report within 48 hours: The official medical report should be written by a physician and contain the following data:

(a) History - the alleged cause of the injury (with dates and times) or malnutrition.
(b) Physical exam - description of the injury (use nontechnical terms) or of the weight gain before and during hospitalization (in ounces per day, not the metric system).
(c) Lab tests performed - eg. x-rays
(d) Concluding statement on why this represents non-accidental trauma, or severe underfeeding. Also any special concerns regarding the child's safety.

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This report should be written (on ordinary paper) by the pediatric intern in charge of the case. It should be taken to the C.P.T. coordinator (room 3008) for typing on the official form. She will also have it critiqued by the team pediatrician.

10. Obtain social service and psychiatric consultation within 72 hours: Explanation of these can be that they are hospital policy. The C.P.T. coordinator will schedule these appointments. The psychiatrist determines how safe the home is, how disturbed the parents are, and how likely they are to accept therapy. The social worker evaluates the marital relationship and the total family problems. The pediatrician is not usually able to do this. Child Welfare usually carries out their own evaluation concurrently. The evaluations by the hospital social worker and psychiatrist should be typed and submitted to Child Welfare.

11. Refer parents who need crisis psychotherapy: After diagnosis, some of these parents will experience anger and other strong emotions that require ventilation. Also some of them have strong dependency needs. The pediatric intern or resident may desire to personally help these parents. Usually, however, he will not have the time. When these parents obviously need a long talk with someone about other than their child's medical status, they can be referred to the C.P.T. social worker or coordinator. If the parents threaten to take the child out against medical advice, a court hold should be obtained. Any member of the C.P.T. or the hospital administration can assist with this.

12. Attend C.P.T. disposition meeting: The psychiatrist, social worker, pediatric consultant, housestaff, child welfare worker and C.P.T. coordinator should meet within 3 working days of admission. All evaluations should have been completed. All possible suspects (including babysitter, neighbor's kids, boyfriends) should have been interviewed. This multidisciplinary, interagency meeting should decide upon the best immediate and long range plans for this patient. The C.P.T. coordinator will convey these recommendations by phone to child welfare and any other agencies involved, if they have not been able to attend. The composite recommendations of this meeting are typed and copies distributed to all involved individuals.

13. Discharge the patient when Child Welfare authorizes it: Child Welfare first decides whether the child needs a dependency hearing for court enforced follow-up or foster home placement. The pediatrician is obligated to keep the child in a protected environment until Child Welfare decides on the safest course of action. If this process takes too long, we can ask Child Welfare to temporarily hold the child in a foster home via a temporary custody hearing.

14. Provide follow-up of physical status: The battered child needs more frequent well child care than the average child. He should be seen weekly for awhile. He needs follow-up to detect any recurrence of physical abuse. If he has sustained head injury, he needs follow-up for mental retardation, spasticity, and subdural hematomas. If he has experienced nutritional neglect he needs careful monitoring of weight gain. These return visits can be provided by the pediatric housestaff member who was involved initially on the ward. Another option is to have Dr. Gray or Dr. Schmitt provide follow-up care. If the parents come from a great distance, the pediatric follow-up should be assigned to a physician in that community. He should receive telephone notification prior to discharge. If the child is reinjured and the injury itself does not warrant hospitalization, Child Welfare should be called to decide what protective services should be provided.

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15. Child Welfare will provide psychosocial follow-up and treatment: The pediatrician should not feel responsible for the restoration of these families to emotional health. Child Welfare is primarily responsible for coordination of psychotherapy. This therapy should begin while the child is still in the hospital. Child welfare makes home visits also. Child welfare finds the patient who becomes "lost to follow-up." The pediatrician can contribute to the therapeutic process by giving the parent his telephone number to call "if things get rough." It is best if the parent has several people available as a lifeline. After the parent calls, Child Welfare should be notified that the parent is upset and needs urgent help.

Revised September 1973

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CHILD PROTECTION TEAM, UNIV. OF COLORADO MEDICAL CENTER - Denver, Colorado

C. Henry Kempe, M.D., Director

Date & basis for establishment of CA'N program	1972
Location	Med. Ctr.
Affiliation (hospital, Dept. Health, Dept. other agency)	Med. School
Medical director affiliation	Yes
Facilities (Grand Jury, public, private, state institutions, other)	State
Maximum # of pts. in CA'N	75,000.
Funding mechanism	Yes
Copy of budget attached	No
PATIENT STATISTICS	Ctr-126, Hosp.
# newborns/year	2,192
# outpatients/year	44,000
# CA'N patients admitted/year	31
# CA'N patients treated in outpt dept/year	0
# previously abused/year	1
# neglected/year	94
CA'N TEAM	
Composition & qualifications of CA'N:	
Head	Pediatrician
Coordinator	80
Hospital Administrator	100
Pediatrician	0
Psychiatrist	Two (1) 10% 1 - 80
Psychologist	(2) Psychiatrists 10 & 50
Social Worker	No
Attorney	Three No
Other (state)	50 to 100
	Psychologist Yes
Does Team see all suspected cases of abuse?	100
" " " " " neglect?	Yes
Are there written procedure guidelines for Team?	No
Are they followed fully?	Yes
	Team
PATIENT FLOW	
Direct (through Emergency Room)	50
Through Pediatric Clinics & wards	2
Through Child Welfare Social Worker	1
Through another agency	2
Through private physician	2
Through parental call for help	40
Through police	1
Through school	2
Other (state)	
INFORMATION COLLECTION ON PATIENTS	
Full medical, social, psychological history	Yes
Family police information on child and parents	Yes
DIAGNOSIS - IDENTIFICATION	
Is CA'N team responsible to establish "case" status	Yes
By individual physicians or CA'N staff	
Personality sketches of and visit to child by Coordinator and husband	
TREATMENT	
All medical services made available	Yes
Psychological services	Yes
EVALUATION of child	
for medical disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS	Yes
Evaluation of SIBLINGS	Yes
REHABILITATION	
Medical	Yes
Psychological	Yes
Short term rehabilitation	Yes
Long term rehabilitation	Sometimes
Referral to other treatment centers	-
If patient appointments are not kept, is there follow up and by whom?	Hosp. S.W.
COST OF CA'N'N CARE	
Estimated cost for Treatment, Evaluation, Rehabilitation	$128./day
FOLLOW-UP	
Is State Welfare in progress from Protective Services?	Varies
CASE CONFERENCES - in facility	Yes
How regularly: weekly, bi-monthly	Weekly
All members of team present	Yes
Conference on patient call	Yes
Pediatrician host commonly attend	Yes

COMMUNITY CHARACTERISTICS	
Boundaries for population surrounding health facility	See
Economic class	text
Ethnic composition	
POPULATION SERVED BY PROGRAM	
All from surrounding community	See
Economic status	text
Ethnic composition	
Patient population not selected by center	
Special category	
COMMUNITY RESOURCES	
Day Care Center 24 Hours	
Crisis Nursery /24 Hours	Yes
Foster Home	Yes
Therapeutic foster home	Yes
Hotline	Yes
Parent Aides	Yes
Parents Anonymous or other self-help group	Yes
Homemaker	Yes
Other, as Public Health Nurse	Yes
If available, would you use all or most of these?	Yes
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	No
Does it relate with hospital team?	
EDUCATION	
in Community - lay public	Yes
in Hospital	Yes
School of Medicine, Law, Nursing	Yes
Public schools	Yes
Police Department	Yes
Other (state) Social Work schools	Yes
PROTECTIVE SERVICES	
Hospital and Community cooperate	?
Can child be held without parents' consent?	See text
CRITERIA for considering home "safe" developed with hospital participation	Yes
REPORTING mandated?	Yes
Abuse reports - by Team or individual? Team dec.	Coord.M.D.
Report sent to	Child
Investigated by	Welfare
Neglect reports - by Team or individual?	Same
Report sent to:	as
Investigated by:	Abuse
Reporting procedure weekends, holidays, 24 hours?	Yes
Parents informed of reporting?	
REGISTRY - in hospital	Yes
Central registry in state or community	Yes
Is central registry effective?	?
Can it be used by CA'N team?	No
Can complaint be expunged from record?	No
DISPOSITION	
Joint decision by team and protective service	Yes
Conference with family before disposition hearing	Yes
% returned home	50
% returned home under protective custody	-
% referred to Foster Care	50
% termination of parental rights	10
Any team members involved in court hearings?	Yes
GUIDELINES AND CRITERIA	
for Abuse - written? unwritten, flexible on individual basis	Written
for Neglect - written? unwritten, flexible on individual bases	Written
Established criteria for considering home "safe"	Yes
PROFILE OF ABUSER	
Alcohol a factor in abuse	Yes
Drugs a factor in abuse	No
	No
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x rays?	Yes
Surveillance of newborns in abusive family?	Yes
Observations by obstetrical nurses?	Yes
Identification of "high risk" mothers in prenatal clinics?	Yes
FAMILY COUNSELING?	
Family planning recommended?	Yes
RESEARCH - ongoing	Yes
New study or expansion of research planned	Yes

SITE VISIT NO. 3

William Beaumont Army Medical Center
El Paso, Texas
December 17, 1973

The William Beaumont Hospital Child Abuse Program, known as the Infant and Child Protection Council (ICPC), a pioneer and model program for the armed forces, was established in 1967. The Army has just adopted, as of February 20, 1974, uniform regulations for the treatment of child abuse, in the writing of which the ICPC director, Lt. Col. John K. Miller, M.S.W., played a leading role. The program, in an intensely busy general hospital of notably high morale, serves a wide geographic area for the armed forces and catchment for the Indian Services of New Mexico and Arizona. There are affiliations with three medical schools and active ward and clinic teaching.

Fort Bliss, population 60,000 is an Army post, administratively separate from, but served by the William Beaumont Army Medical Center. William Beaumont is a big, new general hospital situated on a hill overlooking civilian El Paso, population 300,000, and the broad, endless mountains and plains of west Texas. It is one of seven hospitals in El Paso, but is the center of a single health care system for the military community in the area. It is also the Trauma Center.

An army base is another country. Nearly everyone knows everyone else, except for the lower enlisted grades. Although army salaries have just been raised, and efforts are being made to enfold families of lower grade married enlisted men into army life, it is still a more tightly structured and restricted life than the civilian counterpart. Many enlisted families live in trailers and are socially isolated. The Army does not extend to privates the services it provides to help officers get settled in new locations.

The children who enter the child abuse program come from families of all military ranks but primarily the middle enlisted grades. A typical case is said to be that of the young soldier and his wife who were poorly prepared to assume family responsibilities and break down under the additional stress of military life. When older parents are involved, child abuse is often secondary to alcohol abuse. The Medical Center averages 190 pediatric out-patients and 242-3 pediatric admissions a day.

William Beaumont Army Medical Center

The hospital has had 259 cases of child abuse/neglect in the past 4-1/2 years; of these, 227 have been closed. The total number of cases since the program began in 1967 has been 323. There were 11 deaths between 1967 and 1971, and in the past year, 5 more. To date, the deaths in the program have all been due to neglect rather than abuse.

The average of about four child abuse cases diagnosed a month has been fairly constant over the years. Twenty cases are active at any given time. About 33% of the cases are abused; over 33% are neglected, and 10% are both. The average hospital stay of an abused child is 4.4 days.

Military families reside in both the civilian community and on army posts. Many of the families, especially the lower ranking personnel, reside off-base. In the fiscal year 1971 the population was characterized as follows:

37% active duty "on post" families:
38% active duty "off Post" families;
24% retired "off post" families;
7% "Waiting Wives" "off post" families;
4% Foreign Troop "off post" families.

There is no civilian child abuse program in El Paso. The military program has no relationship to the local medical community in spite of efforts on the part of the hospital team, nor, with exceptions, with attorneys.

The interdisciplinary committee which makes up the ICPC of the Medical Center meets every other week to receive complaints of child maltreatment and plan management and coordination of reported cases. It serves as a "collective body to support, supervise, and assist individual Council members." The Council is composed of representatives from social work, pediatrics, the Army Health Nurse Section, psychiatry, the Army Community Service Agency, the staff Judge Advocate, the local civilian Child Welfare Office of the State of Texas, and volunteers working with child treatment cases. The Council is chaired by the Chief of Social Work Service, and this Service administers the program. Others who may attend include social work students, other trainees, and internes. Minutes are kept.

Each member of the Council is not only a planner and consultant to the other members, but carries a case and works with one or more families. Individual assignments are made on the basis of the person most likely to be effective in that situation.

Because of the large percentage of "off base" families, the Child Welfare unit of the Texas State Department of Welfare also has a representative on the Council.

The ICPC is a total hospital program, relying heavily on social work personnel. Cases are referred from various sources: neighbors, the emergency room, hospital wards or clinics, public schools, the police, and self-referral (5%). Ten percent of pediatric emergency room visits, and 30% of emergency room trauma under age three are considered abuse, and 30% of ward admissions are for suspected abuse and neglect. All suspected cases of abuse are seen by the team.

There is no special funding and costs do not appear determinable. Inpatients are charged $3.50 per day--essentially for their food. Only military dependents are treated.

Regulation 40-3-7 (attached) outlines the program's diagnostic criteria and procedures. The emphasis on follow-up in these guidelines is notable. In some aspects, follow-up is facilitated by a military "total care" system. When an army family is transferred, the medical records are forwarded. In actuality, there are delays and defects in this system.

The high profile of the abuse program, and the accepting, therapeutic approach of the team, have resulted in high parent cooperation. Parents participate in the decisions. Eighty-one percent of the patients are returned home, and permanent removal of children from abusing parents has occurred in only one percent or less of cases.

On the base, the social worker and an Army health nurse follow up child abuse cases who do not keep appointments. Sometimes the commanding officer is asked to put pressure on the soldier to bring in the child. Confidentiality is, however, a concern, especially under the new regulations.

One of the weaknesses of the program is in the area of education beyond the individual case level. Technically, the ICPC is not charged with investigation, the only investigative body being the military police. The MP's are 18 to 20 year olds who tend to regard child abuse as a criminal offense, so that when they go out on a call, they bring the parent in on a criminal charge (abuse) or a misdemeanor charge (for neglect), either of which allows MP disposition without notifying the ICPC team.

William Beaumont Army Medical Center

Children temporarily taken from their parents by legal process are placed in Texas foster homes. The present judge of the local juvenile court has been cooperative with the child abuse team. Although there are legal complications between Federal, state, county, and military authorities, an effort is made to maintain personal relationships as well as possible and work together. The team believes this effort has been largely successful.

A different problem is that of hiring or involving new personnel. Assigning personnel, even psychiatrists, to child abuse work is successful only if they are enthusiastic. Failure of psychiatrists to cooperate with the social worker detracts from the effectiveness of the program. Dr. Miller and the social worker have an on-going educational program for the house staff, with constant reinforcement. Continuing education is also directed to the community, which is ,nevertheless, generally disinterested. Unfortunately, in El Paso, Justices of the Peace with no medical training are permitted to pronounce persons dead. They are said to exhibit indifference to a surprising number of cases that the ICPC group would like to see autopsied.

Community resources on the Army base include a day care center which is operated for the benefit of parents visiting the hospital, and is not open in the evenings. Twenty-five percent - thirty percent of hospital admissions are "social", to provide temporary relief for family crisis. There is also a chaplain "hot line", not specifically for child abuse. The Army Community Service Center, a professionally directed and volunteer staffed service found on every Army post, helps military families with many problems.

The site visit team was impressed with the requirement that every child under age three admitted to the hospital be seen by a pediatrician with an interest in child abuse. Also outstanding at William Beaumont are the interdisciplinary approach, the individual case work responsibility of team members, the team record system, the forwarding of records on transfer, the essentially 100% parent cooperation, the completeness of the reporting, the financial and social aid through the Army Community Service Center, and the attitude that tangible services (financial aid, transportation, home visits) are more effective than psychotherapy with maltreating families. Here is an opportunity to watch child abuse in a paternal, regimented setting.

William Beaumont Army Medical Center

Additional information on file at the Academy office:

1. Questionnaire.

2. Site visit reports by individual team members: Dr. Bates, Ms. Elmer, Ms. Pambrun, Dr. Steele, Ms. Tenne.

3. A review of 94 cases of child maltreatment, 1 December, 1973, unpublished.

4. The "maltreatment syndrome" in the military community. LTC John K. Miller, WBAMC. Presented to Current Trends in Army Social Work Course, San Antonio, Texas, August, 1972, unpublished.

DEPARTMENT OF THE ARMY
HEADQUARTERS
WILLIAM BEAUMONT ARMY MEDICAL CENTER
El Paso, Texas 79920

REGULATION
NUMBER 40-3-7

20 September 1973

INFANT AND CHILD PROTECTION COMMITTEE

1. General: The purpose of this regulation is to establish a program of protective services for children who are abused, neglected, or abandoned and are members of, or reside with, military families serve by William Beaumont Army Medical Center. It is the intention of this command that the welfare of these children will be of primary interest and that every possible effort will be provided to assist the adults responsible for their care in strengthening family life and parental supervision. While the number of such situations may represent a small percentage of all military families, each case represents a personal tragedy to the children affected, their families, and a serious health and morale problem to the command and to the Army.

2. Definitions:

a. Child: Any person under the age of 18 years.

b. Maltreatment: Abuse,neglect, or sexual exploitation of a child.

c. Abuse: Injury or trauma received as a result of nonaccidental causes.

d. Sexual Abuse or Exploitation: Using a minor child for sexual gratification.

e. Neglect: Acts of commission or omission which result, or could reasonably be expected to result, in injury, trauma, or serious ill health to a child. This includes abandonment or lack of adequate supervision; malnourishment; repeated exposure to dangerous drugs, chemicals, or equipment; parental rejection; or other conditions in the home which adversely affect the emotional growth of children and repeated truancy of otherwise eligible school age children. For purposes of this regulation, children medically diagnosed as "failure to thrive" or irresponsibly left unattended will be considered neglected.

This Regulation supersedes Regulation Number 20-1-7, dated 13 Nov 1969.

Reg 40-3-7

3. Organization of Child Protective Services Program: A standing committee of the hospital known as the Infant and Child Protection Committee (ICPC) is organized to serve as a vehicle for the clinical investigation, coordination, and management of suspected or established cases of child maltreatment. Additionally, this committee will promote programs of education, public information, consultation and research aimed at prevention of child maltreatment. Trained volunteers, "parent aides," emergency homemakers, and others may also be used in this program. The committee shall establish:

a. A clearly defined means by which suspected cases of maltreatment can be easily reported to the committee.

b. A procedure for insuring that timely, appropriate action is taken to protect the welfare of all children coming to its attention whose health may be endangered by maltreatment.

c. A program of education of hospital staff and others in the command to the recognition of child maltreatment cases.

d. A system for reporting all cases of abused,neglected, or sexually exploited children to civilian authorities in accordance with the laws of the State of Texas. This command shall report all suspected cases to the Regional Office of the State Department of Public Welfare.

e. A program that insures that families who are subjecting their children to maltreatment will be offered assistance in strengthening family life and overcoming the problems that lead to maltreatment.

f. A method of following referred cases until the safety and health of the affected children are reasonably assured. This will include notification of child protective agencies in other communities to which the family is moving whenever there is any reason to suspect that the child (ren) may be subjected to maltreatment again.

g. The committee will keep abreast of all Texas legislation which has any bearing on this broad problem of infant and child protection. The committee will act as the dissemination means of keeping the medical staff and command informed of changes in existing statutes.

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4. Membership of the ICPC:

a. The Infant and Child Protection Committee shall be composed of representatives from Department of Pediatrics, Department of Psychiatry, the Social Work Service, the Mental Hygiene Consultation Service, the Army Health Nurse Section, the Staff Judge Advocate's Office, the Provost Marshal's Office, and the Army Community Service Agency. The Director of the Regional Office of the State Department of Public Welfare, or a designated representative, will be invited to serve as ex officio member of the committee. The commander of the hospital will appoint the chairman.

b. The ICPC shall meet on call of the chairman, or not less than monthly, to conduct its business. The committee will serve as a professional body guided by the ethics of the hospital with regard to confidentiality and mission of assisting those in need of services.

c. The focus of the program shall be on protection of affected children rather than punishment of responsible adults. In some cases disciplinary or judicial proceedings may still be initiated by appropriate authorities. If a family declines professional assistance and a majority of the committee believe risk exists to a child's health, the case will be referred to the hospital commander for information and guidance. The Regional Director of the State Department of Child Welfare may also pursue the matter independently since this agency is charged by law with invoking child protective services for the State.

5. Reporting Child Abuse and Neglect:

a. All physicians, nurses, teachers, social workers, psychologists, commanders, members of the Provost Marshal's Office, "on post" residents, civilian employees of the federal government or its contractors, or any other person shall report to the Child Protective Services Committee any case where there is reasonable cause to suspect that a child may be maltreated.

b. This report shall be made by the most expedient means available and may be followed by a written report if requested. Any person making such a report or participating in a judicial proceeding resulting therefrom shall be immune from any liability, civil or criminal, that otherwise might be incurred or imposed so long as he/she acted without malice.

c. The Child Protective Services Committee upon receiving such report shall immediately take necessary action toward preventing further abuse or neglect, safeguarding and enlarging the welfare of the child(ren), and preserving family life whenever possible. If the injury or neglect of the child is so serious that criminal or civil prosecution may occur, the Protective Services Committee will, in addition to other actions taken under this regulation, advise the medical facility commander.

d. Upon presentation of a court order from a civilian juvenile, or other duly authorized judge, to the Staff Judge Advocate or his representatives, a child may be removed by a licensed child care agency from a family residence on post or military hospital for purposes of temporary protection.

e. The Child Protection Services Committee will assist civilian agencies inproviding protective services to eligible military families residing off post.

6. Examination and Reports:

a. All cases of suspected child maltreatment referred to William Beaumont Army Medical Center for physical examination or medical treatment will be carefully documented by the attending physician, and a pediatric consultation immediately obtained. A member of the hospital Social Work staff will be on call 24 hours a day to assist the pediatrician and attending physician in conducting initial interview and making disposition plans.

b. The examination should include location and description of bruises, contusions, other injuries, and general appearance. An account of how the injuries were said to have occurred should be obtained from the responsible adult or others bringing the child to the hospital. The parent(s)' behavior and attitudes regarding the examination, medical condition, and questions posed should be recorded. Hospital staff shall document records and make observations in such a manner they can accurately describe events in a courtroom should they be required to testify. All information should be recorded on standard medical forms. In addition to routine physical examination, children suspected of maltreatment will, unless medically contraindicated, also receive total body X-rays (including lone bone and skull series) and color print photographs will be obtained. This information will be identified along with date the photographs and X-rays were taken. Duplicate copies of records may be kept by the Child Protective Services Committee to preclude possible loss of case material.

7. Hospitalization, Admission, and Removal of a Child:

a. In some cases, children who are not seriously injured may still need admission for immediate protection (i.e., psychotic parents, abandonment, etc). When in doubt, the child should be admitted with an explanation to the parent that the cause and extent of injuries are unknown and further observation is indicated.

b. If a parent or responsible adult refuses to admit the child or attempts to remove a child from the hospital after admission and the hospital professional staff has reasonable cause to believe the child's life may be jeopardized, an immediate call should be made by the responsible physician to the Social Work Service (or Social Work Office on Call) to initiate a petition for temporary custody by the Juvenile Court.

8. Waivers of Privileged Communication: The physician-patient, husband-wife privilege, or any privilege except the attorney-client privilege, provided for by professions such as the practice of social work or nursing covered by law or a code of ethics regarding practitioner-client confidence, both as they relate to the competency of the witness and to the exclusion of confidential communication, shall not pertain in any civil or criminal litigation in which a child's neglect, dependency, abuse, or abandonment is in issue nor in any judicial proceeding resulting from a report submitted pursuant to this regulation.

The proponent agency of this regulation is Social Work Service. Users are invited to send comments and suggested improvements to Chief, Social Work Service.

FOR THE COMMANDER:

ROBERT W. FEDERMAN
MAJ, MSC
Adjutant

DISTRIBUTION:
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WILLIAM BEAUMONT ARMY MEDICAL CENTER
El Paso, Texas

LT COL John K. Miller, Director of CA/N program

Date & basis for establishment of CA/N program	9/67
Location	Hospital
AUSPICES: Hospital, Medical school, Health Dept., other (explain)	Army
Medical School affiliation	-
FUNDING: Grant (type), public, private, state institution, other	Army
Attachments if any to CA/N	
Funding restraints	
Copy of budget attached	
PATIENT STATISTICS	
# inpatients/year	1,000
# outpatients/year	100,000
# abused patients admitted/year	50
# abused patients treated in outpt dept/year	-
# sexually abused/year	3
# neglected/year	50
CA/N TEAM	
Composition & time in CA/N	
Head	
Coordinator — LT COL, MSW	15
Hospital Administrator — Clerk	10
Pediatrician	0
Physician — Three 4%	(1) - 10
Surgeon	-
Nurse	3
Social Worker — Three - 4%	(1) 50
Attorney	1
Other (state)	-
Does Team see all suspected cases of abuse?	Yes
" " " " " neglect?	Yes
Are there written, procedural guidelines for Team?	Yes
Who developed them?	Team
PATIENT FLOW	
Intake — through Emergency Room	6
% through Pediatric Clinics & Wards	38
% through Child Welfare Social Service	12
% through neighbor report	16
% through private physician	0
% through parental call for help	5
% through police	2
% through school	3
% Other (state) — Other Posts, nurse, Red Cross, chaplain, etc.	18
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological history?	Yes
Family profile? (information on sibs and parents)	Yes
DIAGNOSIS IDENTIFICATION	
By CA/N team according to established criteria	Yes
By individual physician or ER staff	
Previously identified and sent to center for confirmation and treatment	
TREATMENT	
24 hr medical/surgical treatment available	Yes
Psychological service	Yes
EVALUATION of child	
for emotional disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS?	Yes
Evaluation of SIBLINGS?	Yes
REHABILITATION	
Medical/surgical	Yes
Psychological	Yes
Short term rehabilitation	Yes
Long term rehabilitation	Yes
Referral to other treatment center	Sometimes
If return appointments are not kept, is there follow up and by whom?	Army nurse
LOCUS OF PATIENT CARE	
Delineated for Treatment, Evaluation, Rehabilitation	See text
FOLLOW UP	
Is there feedback to physician from Protective Services?	Yes
CASE CONFERENCES — in facility	Semi-
Held regularly, weekly or monthly	monthly
All members of team attend	Yes
Conference on special call	Yes
Professionals from community attend?	Sometimes

COMMUNITY CHARACTERISTICS	
Boundaries for population surrounding health facility	See
Economic class	text
Ethnic composition	
POPULATION SERVED BY PROGRAM	
All from surrounding community	See
Economic status	text
Ethnic composition	
Patient population not selected by center	
Special category	
COMMUNITY RESOURCES	
Day Care Center 24 Hours	No
Crisis Nursery	No
Foster Home	Yes
Therapeutic foster home	No
Hotline	Chaplain
Parent Aides	Yes
Parents Anonymous or other self-help group	No
Homemaker	Yes
Other, as Public Health Nurse	No
If available, would you use all or most of these?	Yes
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	No
Does it relate with hospital team?	
EDUCATION	
in Community - lay public	Some
in Hospital	Yes
School of Medicine, ~~XXX~~, Nursing	Yes
Public schools	PTA
Police Department	Sheriff
Other (state)	0
PROTECTIVE SERVICES	
Hospital and Community cooperate	Yes
Can child be held without parents' consent?	no problem
CRITERIA for considering home "safe" developed with hospital participation	No
REPORTING mandated?	Yes
Abuse reports - by Team or individual?	Team dec.
Report sent to:	Coord.
Investigated by:	Welfare
Neglect reports - by Team or individual?	
Report sent to:	Same
Investigated by:	
Reporting procedure weekends, holidays, 24 hours?	Yes
Parents informed of reporting?	Yes
REGISTRY - in hospital	Yes
Central registry in state or community	Yes
Is central registry effective?	?
Can it be used by CA/N team?	No
Can complaint be expunged from record?	No
DISPOSITION	
Joint decision by team and protective service	Yes
Conference with family before disposition hearing	Yes
% returned home	81
% returned home under protective custody	0
% referred to Foster Care	19
% termination of parental rights	1
Any team members involved in court hearings?	Yes
GUIDELINES AND CRITERIA	
for Abuse - written? unwritten, flexible on individual basis	Written, flexible
for Neglect - written? unwritten, flexible on individual basis	Flexible
Established criteria for considering home "safe"	-
PROFILE OF ABUSER	Parents, sibs, stepparent
Alcohol a factor in abuse	Yes
Drugs a factor in abuse	Rarely
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	Yes
Surveillance of newborns in abusive family?	Yes
Observations by obstetrical nurses?	Yes
Identification of "high risk" mothers in prenatal clinics?	Some
FAMILY COUNSELING?	Yes
Family planning recommended?	As appropriate
RESEARCH - ongoing	Yes
New study or expansion of research planned	-

SITE VISIT NO. 4

Children's Protective Services Center
Kauikeolani Children's Hospital
Honolulu, Hawaii
February 7, 1974

The Island of Oahu, population 650,000, is a county in the state of Hawaii, population 780,000. Oahu is a military center, with 150,000 active, dependent, or retired military, and the commercial center for the Islands. Tourism and agriculture are principal industries.

Hawaii is a melting-pot with Caucasian, Japanese, Chinese, Filipino, Polynesian, and mixed races. The determination of ethnic status is generally subjective. The climate is benign.

The Child Abuse and Neglect program in Hawaii was started in 1969 as a recognition of community need. An antecedent program involving juvenile court, police, and public welfare had existed since 1956. In 1967 the Hawaii mandatory child abuse law was enacted, requiring reporting of child abuse to the Department of Social Services by doctors, dentists, osteopaths, others engaged in the healing arts, social workers, teachers, and coroners. Following this, in 1969 the Children's Protective Services Center (CPSC) was established as a unit of the Hawaii Department of Social Services and Housing. This unit is composed of the Kauikeolani Children's Hospital (KCH) and the Department of Social Services and Housing (DSSH), by contractual agreement and budget negotiated annually. The CPSC is housed in the KCH, and the physician assigned to the PSC serves as medical director responsible for supervision of the medical staff. Dr. George W. Starbuck has served as full-time medical director of the CPSC of the Hawaii DSSH for the past 3-1/2 years. The CPSC staff are in and out of the KCH. A new hospital being planned will entirely house the CPSC. Both the hospital administrator and DSSH consider it an asset for the CPSC to be housed in the hospital. The hospital's outpatient and inpatient services are fed by the program, and mutual staffing benefits both the hospital and the CPSC.

The Center is maintained for the purpose of diagnosis, detection, evaluation and treatment of children who are abused and neglected and also for study, research and education on the subject of child abuse and neglect.

The marked increase in child abuse and neglect cases reported in Hawaii since the Center's program began is shown:

CASES REPORTED TO CENTER

	Abuse	Neglect	% Confirmed
1967	79	9	
1968	49	18	
1969	228	208	
1970	509	463	50%
1971	543	462	50%
1972	609	442	43%

The 1972 case reporting gives a rate of 120/100,000 population, probably one of the highest in the nation.

The marriage of CPSC and KCH results in an unusual patient flow. Children enter the program through anonymous calls for help, relatives, and public health nurses as well as the more usual channels (doctors, social workers and police). The high percentage of school referrals and parent referrals is noteworthy. Only about 10% of reported child abuse and neglect cases is admitted to the hospital.

Whereas there is no problem about cooperation between CPSC and KCH, there is a limit to the amount of service that can be given. The annual nature of funding is a cause of uncertainty. The program is running at or near capacity, with the number of complaints surpassing the number that can be accepted into the program. Each case reported is screened, and the appropriate ones are assigned to a worker who, after suitable investigation, may/may not confirm the case as abuse or neglect. Only a small percentage of the confirmed cases of CA/N is hospitalized. (30/500 in 1972)

The CA/N team varies in composition according to the need but usually consists of seven members: the pediatrician medical director, Dr. Starbuck, a social worker, a nurse, two psychologists and two psychiatrists. In addition, representatives of other disciplines involved in the case are, for that case, a part of the team. This may include the military, police, attorneys, etc. The team meets once weekly at a conference to review one or two cases. A full evaluation would include a social history, psychiatric examination and psychologic evaluation. Individuals on the team are available for consultation at any time to Department of Social Services workers, and the workers who bring the cases to conferences regard the team as a consultative resource. The workups of the cases observed by the site visit team are thoroughly and freely discussed. The team can only make recommendations. The social worker, who presents the case and consults with the other disciplines, makes the final disposition report to DSSH and is responsible for carrying out the treatment with the child and family.

Once assigned a case in the CPSC, a social worker follows it through until a plan of service is developed. Cases are held no longer than 90 days; in that time, case must have been diagnosed

and a service plan developed. At the time of transfer of the case from the Center to an outlying unit, the suspension date is three months away. At the end of three months, a follow-up report is sent back to the team. This enables the Center to request that the case be brought back to the team at that time.

The CA/N team is backed up by a second team, the "resident" team, which includes members of the first team except for a different psychologist or psychiatrist. "Mini conferences" can also be arranged quickly and with maximum flexibility to assist in resolving specific questions that need urgent attention. Military physicians and social workers may join in cases being teamed at CPSC whether or not they are military dependents; in fact, this is encouraged and military personnel are regularly invited to attend the conferences. When the cases referred for services to the CPSC are military dependents, the CPSC consults the military child abuse and neglect management team, providing three non-voting members: the pediatric nurse, medical director and social work supervisor.

If a child appears to be in jeopardy and the parents refuse admission, the facts are reported to the Juvenile Crime Prevention Division. They review the case, and may then book the child on a "PINS" petition (Person in Need of Supervision). This gives the social worker 48 hours to prepare a custody request through Family Court. In approximately 10% of all referrals, a child is held against the parents' wishes.

The CPSC unit works essentially as a crisis-handling service, providing evaluation, prescriptive recommendations and short-term treatment. When the immediate crisis has been handled, the case is either closed or referred elsewhere for follow up. Some workers may continue to work with the parents, but usually parents are referred to mental health clinics or social service agencies, such as the Catholic Social Service, or private agencies. A few cases are referred for private psychiatric treatment. Treatment of the family by persons at the Center generally does not extend longer than the three months cited above, and most cases are seen for shorter periods.

The CPSC has a 24-hour hot line for emergencies. Telephone referrals are received via the hospital switchboard. If it is an emergency call or after-hours, the information is transmitted by the hospital switchboard to the CPSC after-hours worker for action. Written referrals are forwarded to the Child Protective Services Unit supervisor for assignment to a protective services worker for immediate investigation. Further guidelines for the Center are available from the state of Hawaii.

Not all cases are worked up by the team. The social worker at the Center may decide to handle the case without consultation from the full team. Decisions not to refer a case to the team are reviewed by the DSSH supervisor in the unit. There is always a conference between the family and the social worker.

Kauikeolani Children's Hospital

When a disposition has been worked out and agreed to by the family, the responsibility for treatment is usually referred to the local DSSH unit covering the area where the family resides. This requires that the family establish a relationship with a new therapist. The potential disadvantages of this are clear, especially with families that are slow to trust; but the CPSC team feels there is an advantage in the procedure as well, in that, once the "crisis" is over the family may respond more positively to a person not associated in their minds with the panic of the initial investigation. Furthermore, the new therapist may be able to view the family with less prejudice than the therapist who saw them at their lowest point of integration.

Despite the innovative collaboration arrangement between DSSH and KCH, follow-up continues to be difficult. This is of particular concern in light of the heavy reliance placed by the team on voluntary placement and/or DSSH field workers for continuing protective intervention. Voluntary placement has no time limitation as long as the parents cooperate. Under the law, the DSS decides whether or not a case goes to court. Legal custody orders can be obtained for a maximum of three years, but at the end of that time if the home is still judged unsafe, this can be extended another three years. Termination is rarely asked for, all efforts being made to keep the family together. Most hearings are carried out in chambers with the judge, the attorney for the parents, and an attorney for CPSC from the attorney general's office. A guardian ad litem is not mandatory, and is not appointed in all cases. Actually, infrequent use has been made of the courts, although that picture is changing with the growing concern of several members of the team about the real level of compliance of the family with the treatment program developed by the team once the family is "discharged" back to the local DSSH unit. The concern seemed to the site visit team to be well-founded and in line with the experiences of other CA/N programs, i.e., the good intentions and motivation for treatment of most parents involved in child abuse are highly ambivalent and need external support in the initial months of treatment.

The degree of cooperation between the CA/N team and local DSSH in following through with treatment plans formulated at the hospital is not clear. It appears that autonomy is the rule, and workers can, if they choose, disregard the conclusions of the careful workup by the child abuse team.

One hopeful development related to follow-up is that a Catholic Social Service agency in Honolulu, proximate to the hospital, is beginning to provide therapeutic services in child abuse cases, under contract from DSSH. The number of therapists at the agency who are experienced in this field is small (two or three), but the agency is making concrete plans for expanding its services. At present it has about 50 child abuse cases listed, not all of them active, however.

The DSSH is mandated to maintain a central registry of reported CA/N cases. (Hawaii Revised Statute 350). In reality, the problems are enormous, even at a state level.

A random selection of hospital costs of four child abuse cases hospitalized shows a range from $372 (3 days) to $2248 (18 days, including intensive care). Payment in these cases was by Welfare or insurance. Salaries of team members are paid by the hospital, under contract with the DSSH, except for the Social Work Supervisor, Ms. Lei Lee Loy, whose salary is directly from DSSH. In essence, services are paid by Federal, State, insurance and private funds.

One or more members of the CPSC team can go to the other Islands (counties) to make up, with local members, CA/N teams. Transportation, now essentially only by air, is being developed for CA/N cases between the Islands.

The CPSC has received a foundation grant for a study of high-risk infants and has submitted two other grant requests to Federal agencies. It hopes to participate, with Children's Hospital of Los Angeles and the Children's Medical Center, Boston, in collaborative, controlled research into the effectiveness of the program.

The CPSC operates under a number of stringencies. Research is agreed to in the contract with the State, but not funded. The director solicits funds from private sources and has successfully sought grants. Mandated state agencies are not funded, so manpower for borderline cases is not available, nor is there funding for day care centers, 24-hour day care, crisis nurseries or development of other programs.

The CPSC makes extensive use of voluntary placement. It is not clear whether this is done because of the actual validity, or because it leads to better results, or because it is a means of avoiding unpleasant or unnecessary confrontations.

SUMMARY

The marriage of services at CPSC is an innovative useful idea. It not only makes possible an effective interdisciplinary team approach to CA/N, but also supports the concept that small communities could be serviced by a team of one or more trained CA/N specialists. This team could come and discuss a case on local grounds. Or, appropriate local people could go to a larger area where the team is located, to discuss child abuse.

Kauikeolani Children's Hospital

Additional material on file at the Academy office:

1. Questionnaire.

2. Site visit reports by individual team members: Dr. Bates, Ms. Tenne.

3. Operational Plan for Protective Services for Children. Oahu Branch, Public Welfare Division, Department of Social Services.

4. A statistical report on child abuse and neglect in Hawaii, 1970-1971. Dept. of Social Services and Housing, Research & Statistics Office.

PROTECTIVE SERVICES FOR CHILDREN
OPERATIONAL PLAN
OAHU BRANCH

PERSONS SERVED

Manual Policy 5077 provides that child protective services shall be extended regardless of family income to children who may be in need of protection because they are reported to be:

1. Cruelly treated or physically abused.
2. Sexually abused.
3. Lacking regard for health and/or medical care.
4. Improperly or insufficiently fed or clothed.
5. Living in unsanitary home conditions.
6. Lacking proper care and supervision.
7. Exhibiting anti-social behavior.
8. Abandoned.

In Oahu Branch, the Child Protective Services Unit will handle referrals described in any of the above categories except item 7. Referrals of children exhibiting anti-social behavior (item 7) will be handled by other OB units as part of general CWS or AFDC program.

Written or verbal complaints/referrals of alleged child abuse/neglect shall be accepted from anyone in the community. The parents or caretaker of the child is not requesting services of the agency and is often unaware of the complaint report.

REFERRAL PROCESS AND PROCEDURE FOR ASSIGNMENT OF CASES

1. New Cases:

All new complaints will be received by the Child Protective Services Unit for determination of appropriateness of referral to the unit, and for assignment to a protective services worker for immediate investigation.

a. Written complaints/referrals considered as complaints will be forwarded to the Child Protective Services Unit supervisor for final determination and assignment to protective services workers.

b. Telephone referrals will be received via the hospital switchboard on a 24-hour basis.

1) Supervisor of the CPS Unit shall keep the hospital switchboard and other key hospital personnel informed of the after-hours duty schedule of social work staff.

2. Active Cases:

It is the projected goal that all complaints on active DSS cases will also be investigated by the Child Protective Services Unit; however, this will be dependent on adequacy of staffing of the unit at a given time. (Separate memoranda will be issued to Oahu Branch staff onCPS staffing/capability whenever indicated.)

a. If CPS Unit initially receives the complaint, the CPS supervisor will make immediate and appropriate clearance with the active unit before assigning the complaint for investigation.

b. If the active unit initially receives the complaint of abuse or serious neglect, the supervisor will consult the CPS Unit supervisor for assignment of the investigation to a protective services worker.

c. The active unit may choose to handle its own investigation of the complaint because of its particular involvement in the case.

d. After-hours emergency calls: If the call is initially received by the unit worker or supervisor at home, and immediate investigation is indicated, accept complainant's information and transmit information to child protective services after-hours worker via Children's Hospital telephone switchboard for action.

3. Complaints/Referrals from other Social Agencies shall be clarified to determine if complaint is being made for reporting purpose only, or if complaint is being made for reporting as well as for referral and investigation. (Manual Policy 5079.2)

PROVISION OF PROTECTIVE SERVICES ON 24 HOURS A DAY, 7 DAYS A WEEK BASIS

1. The protective services worker will assume responsibility for the case from point of initial handling of the complainant to the development of a treatment plan for the child and his family. Maximum use of the Children's Hospital multi-disciplinary diagnostic and treatment services shall be made wherever and whenever indicated.

2. The protective services worker shall arrange for the child to be medically examined/treated at the Center except where expediency requires emergency medical care at another hospital, or where parental preference or the family's health plan requires hospitalization in another hospital.

a. The protective services worker will obtain the consent of the parent or guardian for the examination, treatment or hospitalization of the child. If parental consent is not obtainable, immediate legal custody of the child will be obtained from the Family Court in order that agency have the authority to provide the consent.

For the child examined in a facility other than at the Center, a copy of the medical evaluation will be forwarded by the worker to the Center's medical director for review and research purposes.

b. The protective services worker shall not remove a child from his home except with the full consent of the parents or upon order of the Court. Where immediate protection of the child appears necessary and removal of the child is resisted, worker shall enlist the authority vested in the Police in removing the child, and follow up with a request to the Family Court for immediate physical custody within 48 hours. (ManualSection 5529; 5580) (Inter-agency procedures OB-Family Court, DSS Handbook of Community Resources, page F-1 (0).

3. The protective services worker and supervisor will jointly determine need for psychiatric/psychological evaluation of the child and his family, and arrange for such diagnostic evaluations by the Center's psychiatrist and/or psychologist through the Center's medical director. Other resources may be utilized if indicated.

4. The Center Team consisting of pediatrician, psychiatrist, psychologist, protective services supervisor, and protective services worker and other appropriate specialists will jointly share their findings for Team diagnosis, evaluation of the child's needs as well as his parents in order to formulate a treatment plan.

   a. The Team will meet on a weekly basis.

   b. Community agencies actively involved in the child and his family may be invited to participate in the diagnostic conference.

5. The protective services worker shall provide intensive social services to the child and his family to prevent further abuse or neglect while working towards completion of the diagnosis on the child and his family. This will be in accordance with manual policies on Protective Services, Manual Section 5075-5082.

   a. The protective services worker will participate along with other appropriate Center staff in providing diagnostic/treatment services to the child and his parents whether in their own home or while the child is in temporary foster care.

b. The protective services worker will coordinate and see that the child and his family get to the appropriate diagnostic treatment sessions or appointments.

c. Appropriate Center staff will be available for consultation to the social work staff in its provision of social services to the child and his parents or foster parents.

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CHILDREN'S PROTECTIVE SERVICES CENTER, Kaulkeolani Children's Hospital, Honolulu, Hi. — George W. Starbuck, M.D. Director

Date & basis for establishment of CA/N program:	9/69
Location	Hospital
AUSPICES: Hospital, Medical School, Health Dept., other (explain)	DSSH
Yes/no school affiliation	Yes
FUNDING: Grant (type), public, private, state institution, other	State
Allotments if any for CA/N	49,473
Funding restraints	Yes
Copy of budget attached	on file
PATIENT STATISTICS	
# inpatients/year	1,645
# outpatients/year	7,580
# abused patients admitted/year	51
# abused patients treated in outpt dept/year	--
# sexually abused/year	27
# neglected/year (included in abuse)	51
CA/N TEAM	
Composition & % of time in CA/N	
Head Pediatrician	100
Coordinator Pediatrician & Social worker	
Hospital Administrator	No
Pediatrician	100
Physician Psychiatrist - 2 hrs. weekly	
Surgeon	No
Nurse	50
Social Worker	100
Attorney	Consults
Other (state) Psychologist - 2 hrs. weekly	
Does Team see all suspected cases of abuse?	No
" " " " " " " neglect?	No
Are there written, procedural guidelines for Team?	Yes
Who developed them?	DSSH
PATIENT FLOW	
Intake % through Emergency Room	5
% through Pediatric Clinics & Wards	2
% through Child Welfare Social Service	9
% through neighbor report	19
% through private physician	4
% through parental call for help	10
% through police	10
% through school	15
% Other (state) PHN, relatives, anonym.	60
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological history?	Yes
Family profile? (Information on sibs and parents)	Yes
DIAGNOSIS - IDENTIFICATION	
By CA/N team according to established criteria	Yes
By individual physicians or EC staff	
Previously identified and sent to center for confirmation and treatment	
TREATMENT	
24 hr medical/surgical treatment available	Yes
Psychological service	Yes
EVALUATION of child	
for emotional disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS?	Yes
Evaluation of SIBLINGS?	Usually
REHABILITATION	
Medical/surgical	Yes
Psychological	Yes
Short term rehabilitation	Yes
Long term rehabilitation	No
Referral to other treatment center	Yes
If return appointments are not kept, is there follow up and by whom?	S.W.
COST OF PATIENT CARE	
Delineated for Treatment, Evaluation, Rehabilitation	Varies
FOLLOW UP	
Is there feedback to program from Protective Services?	Yes
CASE CONFERENCES in facility	
Held regularly, weekly or monthly	Weekly +
All members of team attend	Yes
Conference on special call	Yes
Professionals from community attend?	Yes

COMMUNITY CHARACTERISTICS	
Boundaries for population surrounding health facility	See
Economic class	text
Ethnic composition	
POPULATION SERVED BY PROGRAM	
All from surrounding community	See
Economic status	text
Ethnic composition	
Patient population not selected by center	
Special category	
COMMUNITY RESOURCES	
Day Care Center/24 Hours	No
Crisis Nursery	No
Foster Home	Yes
Therapeutic foster home	Limited
Hotline 24-hrs in the	hospital
Parent Aides	Yes
Parents Anonymous or other self-help group	No
Homemaker	-
Other, as Public Health Nurse	Yes
If available, would you use all or most of these?	
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	Yes
Does it relate with hospital team?	Yes
EDUCATION	
in Community - lay public	No
in Hospital Nurses, E.R.	
School of Medicine, Law, Nursing	Limited
Public schools	Limited
Police Department	Yes
Other (state) Public Health nurses, media	
PROTECTIVE SERVICES	
Hospital and Community cooperate	Yes
Can child be held without parents' consent?	Yes
CRITERIA for considering home "safe" developed with hospital participation	DSSH
REPORTING mandated?	Yes
Abuse reports - by Team or individual? Anyone on team	
Report sent to:	CPSC
Investigated by:	DSSH
Neglect reports - by Team or individual?	
Report sent to:	Same
Investigated by:	
Reporting procedure weekends, holidays, 24 hours?	Yes
Parents informed of reporting?	Yes
REGISTRY - in hospital	Yes
Central registry in state or community	Yes
Is central registry effective?	Yes
Can it be used by CA/N team?	Yes
Can complaint be expunged from record? By court action	
DISPOSITION	
Joint decision by team and protective service	Usually
Conference with family before disposition hearing	Yes
% returned home	73
% returned home under protective custody	-
% referred to Foster Care	4
% termination of parental rights	Rarely
Any team members involved in court hearings?	Sometimes
GUIDELINES AND CRITERIA	
for Abuse - written? unwritten, flexible on individual basis	Written
for Neglect - written? unwritten, flexible on individual basis	Flexible
Established criteria for considering home "safe"	Developing
PROFILE OF ABUSER Father, mother, stepparent	
Alcohol a factor in abuse	Some,
Drugs a factor in abuse	no stats
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	Some
Surveillance of newborns in abusive family?	Develop-
Observations by obstetrical nurses?	ing
Identification of "high risk" mothers in prenatal clinics?	
FAMILY COUNSELING?	Yes
Family planning recommended?	Yes
RESEARCH - ongoing	Yes
New study or expansion of research planned	Yes

SITE VISIT NO. 5

University of Iowa Hospitals
Iowa City, Iowa
January 7, 1974

Iowa has a population of 3,000,000, one half of whom are farmers. There is a higher proportion of older people than in any other state, except Florida, due not to immigration of the old, but to emigration of the young. The population is rural and conservative, and tends to think in terms of families managing their own affairs. The average farm is about 200 acres and is handled by one man.

There are 99 counties in Iowa. Many families in these counties are relatively isolated. There were 326 possible abused children reported in the state in 1971, 253 in 1972, and 400 in the first three months of 1973, but only a small percentage of the cases reported are seen in the University Hospitals. Most families live a great distance from the hospital. More than half of the counties have never reported child abuse. This may reflect poor awareness of the problem as well as a prevailing reluctance to interfere with other people's problems or with parents' rights.

The pediatric population of Iowa (up to 18 years) is 975,000, and there are 60 pediatricians in the state, 20 of them in Iowa City. The majority of rural physicians is over 50 years of age.

In 1965 the State of Iowa enacted legislation which required health practitioners to report suspected cases of child abuse.

There is no penalty and no requirement for reporting of neglect.

The written report of abuse is to be made to the County Department of Social Services and to the county attorney. Unless both agree to act on a report, it is usually not acted on. The Iowa Child Abuse laws are currently under study; and revision is of popular concern, though the legislative interest is in new child abuse legislation rather than the larger problem of child neglect. The conservative approach of an older population influences the thinking of the state legislature with regard to appropriations.

The University Hospitals are located in Iowa City, a university town of 45,000 in east central Iowa. The state legislature has mandated that all medically indigent shall here receive their care, and a network of buses daily transports patients to and from all portions of the state.

University of Iowa Hospitals

Many of the reported cases of child abuse are low income white agricultural families. Most come to the program from their own homes. Of 75 abused children reported from University of Iowa Hospitals from 1965 through 1973, 48% were under one year of age. Most of the reported cases seen at the University Hospitals are reported by physicians, a circumstance perhaps explained by the hospital being a tertiary referral source.

The child abuse program at the University Hospitals was established in 1965 as the result of passage of the state child abuse law. Under Dr. Gerald Solomons, it receives referrals from all over the state. Local and self-referral cases are also accepted. The cases seen are thoroughly worked up as individuals, but the family is not necessarily studied, as the hospital has no authority outside its doors. A conference is held before discharge with the state protective services specialist (the only one in the state) and the family.

There is very little follow-up. This is due to the distances involved, limitations of the University Hospitals' responsibility to its own walls, and the county system of protective services. Following a final conference, the case is discharged, and responsibility transferred to the county of residence. Ten percent of the 99 counties have trained workers (B.A. degree); 90% do not. Statewide annual turnover of protective service workers is 30%.

The Child Abuse Team at University of Iowa Hospitals is headed by Dr. Gerald Solomons, Professor of Pediatrics, who spends about 10% of his time on CA/N problems. Other members are: the team coordinator, a social worker (15%), a pediatrician subspecializing in psychology (10%), the hospital administrator (3%), and the University legal counsel (3%). The program is not specifically funded. All salaries are paid by the state, and the cost of patient care is paid by the family or the state. Iowa law requires that any indigent person requiring medical care can receive it at the University Hospital and be given money to pay for it, including transportation. Each county has a quota from the state for indigent patients; when this is spent, the county pays for medical care.

Case conferences are held monthly and include, in addition to the team, junior and senior staff involved in the case, other interested students and staff, and local agencies. Minutes are kept of the conferences.

When a suspected CA/N case comes to the hospital, the parents are interviewed, a complete workup is done, all possible information is obtained from the local Department of Social Welfare, and the team decides whether or not to report. When the child is admitted, he is the patient of the senior staff man on the ward. If it is considered necessary to hold a child in the hospital, the CA report is made and a 30-day hold can be obtained from the court.

University of Iowa Hospitals

The Department of Social Services must make a complete report within 96 hours of the first report; this includes a home visit. The child may be held in the hospital even when medically well.

Final disposition is made by the Department of Social Services, the county attorney, and the Juvenile Court Judge. The hospital team may testify if asked, but by law the University is not permitted to make recommendations. If the child is put into foster care, it is usually in another county to avoid stigmatizing the family.

There is a systematic review of old cases every two months. A review made by Mrs. Michael in 1972 of 49 suspected abuse cases who had been reported from University of Iowa Hospitals since 1965 produced a nearly complete report on the location, if not, the condition, of these children. Three were known to be dead, 5 had been adopted, 2 were in nursing care institutions, 23 were in their own homes, and 12 were in foster care. Mrs. Michael writes:

> "Of the 21 children reported from this hospital during 1970-71, there are few services being made available to the families at present. There are 10 families for whom no service of any kind is being offered. Five have a visiting nurse, 6 have casework offered, and 2 are currently being seen by psychiatry."

Mental hygiene services in Iowa are being set up on a regional basis with 16 regions. It is hoped to set up protective services to children on the same basis (this was instituted as of March, 1974, after the site visit), but there is resistance to change in the counties, and the authority of the state protective services' officer is limited. Families are not followed once the child is discharged unless the family both wish it and is close by. Essentially, there is no skilled social or psychiatric follow up.

Dr. Solomons has also started a university-wide child abuse council, which includes representatives of nursing, neurosurgery and orthopedic surgery. Mrs. Marianne Michael, ACSW, coordinator of the child abuse team, gives a free community course on child abuse. Ms. Jo Ann Sheeley, MSW, State Protective Services Specialist, who literally knows every abused child in the state, is the third person who makes this program outstanding. Besides cooperating well together, each of them makes numerous appearances on the "media", writes, and travels the state to speak and lecture.

SUMMARY

The program team at Iowa supplies services limited by funding, geographic isolation of families, state laws, lack of insight by local attorneys and judges, lack of experience and time of social workers, and lack of enthusiasm on the part of physicians.

University of Iowa Hospitals

Nevertheless a beginning statewide popular interest in change and a sophisticated staff are prophetic of improvement.

One of the innovative ideas of the program is diagnosing abuse cases as "suspected child abuse or neglect", which facilitates a non-judgmental therapeutic approach, avoids undesired court involvement and leaves the case open for protective services referral.

Additional information on file at the Academy office:

1. Questionnaire

2. Site visit reports by individual team members: Dr. Bates, Ms. Tenne.

3. Report on abused children identified by University of Iowa Hospitals. Marianne Michael, Social Service, unpublished.

PROCEDURES TO BE FOLLOWED IN SUSPECTED CASES OF CHILD ABUSE OR NEGLECT

In order to standardize procedures for cases of suspected child abuse or neglect, the following guidelines have been formulated:

1. All cases of suspected child abuse or neglect must be admitted for evaluation.

2. As the first contact with the parents is of paramount importance in establishing rapport, it is recommended that the senior staff physician, whenever possible, conduct the initial interview.

3. The workup should include a radiological survey of the skull and long bones, and blood studies should include C.B.C., platelet count, prothrombin and partial prothrombin times.

4. If psychological testing is needed, James Stehbens should be notified.

5. When the child is admitted the following personnel should be notified:
   a. Marianne Michael in Social Service
   b. Gerald Solomons

6. If after investigation, it has been decided that the patient will be reported as a suspected case of child abuse or neglect, the following procedure will be carried out:

   a. A letter will be dictated by the intern or resident in charge containing a brief history, physical evaluation, and pertinent laboratory data. The secretary in the typing pool will be asked to transcribe the letter immediately. The letter will be signed by the intern or resident concerned and the senior staff physician on service in the area.

   b. The signed letter will then be hand-carried to the office of Mr. Douglas Williamson of Hospital Administration.

7. No intimation of date of discharge of the patient should be given to the parents without prior consultation with Marianne Michael or Gerald Solomons. This is to insure adequate time being given to the county Department of Social Welfare in order to arrange suitable placement for the child and a conference between county Department of Social Welfare personnel and involved Department of Pediatrics staff.

8. The intern or resident should ascertain from Marianne Michael prior to discharge the legal guardian(s) of the child, to insure that the patient is handed over to the proper individual (e.g.,) Department of Social Welfare, foster parent,etc.).

9. If an attempt is made to sign out against advice a case of suspected child abuse or neglect, the senior staff physician, Gerald Solomons, and Marianne Michael should be notified immediately.

10. On discharge, copies of the letter reporting suspected child abuse to Mr. Williamson, and the discharge summary should be sent to Gerald Solomons for the Child Abuse Committee's file.

11. Monthly meetings are held by the Child Abuse Committee to discuss procedures and all cases seen by the Department of Pediatrics. The junior staff involved are asked, and others are encouraged, to attend these meetings which usually take place on the first Monday of each month at 1 p.m. in the Toddler Conference Room. The members of the Child Abuse Committee are:

Arthur Leff University Legal Counsel
Douglas Williamson Hospital Administration
Marianne Michael University Hospital Social Service
James Stehbens Department of Pediatrics
Gerald Solomons Department of Pediatrics, Chairman

12. Members of the committee are available at all times for consultation but it is emphasized that the responsibility for evaluation, diagnosis, and notification lie with the senior staff physician and junior staff involved with the patient.

Gerald Solomons, M. D.
Chairman, Child Abuse Committee
7/25/73

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UNIVERSITY OF IOWA HOSPITALS,
Child Development Clinic, Iowa City, Ia.

Gerald Solomons, M.D.
Director, CA/N program

Date & basis for establishment of CA/N program	1965 (as
Location	Hospital
AUSPICES: Hospital, Medical School, Health Dept., other (explain)	Med.School
Medical School affiliation	Yes
FUNDING: Extent (type), public, private, state institution, other	State
Allotments if any for CA/N	institution
Funding restraints	None
Copy of budget attached	0
PATIENT STATISTICS	
# inpatients year	2,663 +
# outpatients year	16,084
# abused patients admitted year	20
# abused patients treated in outpt dept year	–
# sexually abused year	0
# neglected year	–
CA/N TEAM	
Composition & % of time in CA/N	
Head — Pediatrician	10
Coordinator — Social worker	15
Hospital Administrator	3
Pediatrician	10
Physician — Psychologist	10
Surgeon	–
Nurse	15
Social Worker	3
Attorney	–
Other (state)	
Does Team see all suspected cases of abuse?	No
" " " " " " neglect?	No
Are there written, procedural guidelines for Team?	Yes
Who developed them?	Team
PATIENT FLOW	
Intake — % through Emergency Room	1
% through Pediatric Clinics & Wards	1
% through Child Welfare Social Service	0
% through neighbor report	0
% through private physician	98
% through parental call for help	0
% through police	0
% through school	0
% Other (state)	0
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological picture? xxxxxxxxxxxxxxxxxx	Yes
Family profile? (Information on sibs and parents)	Sometimes
DIAGNOSIS - IDENTIFICATION	
By CA/N team according to established criteria	Yes
By individual physician or ER staff	
Previously identified and sent to center for confirmation and treatment	Frequently
TREATMENT	
24 hr medical-surgical treatment available	Yes
Psychological service	Yes
EVALUATION of child	
for emotional disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS?	No
Evaluation of SIBLINGS?	No
REHABILITATION	
Medical-surgical	Yes
Psychological	Yes
Short term rehabilitation	Avail-
Long term rehabilitation	able
Referral to other treatment center	Yes
If return appointments are not kept, is there follow up and by whom?	Local f.u.
COST OF PATIENT CARE	
Delineated for Treatment, Evaluation, Rehabilitation	129.71/day
FOLLOW UP	
Is there feedback to program from Protective Services?	None
CASE CONFERENCES - in facility	
Held regularly, weekly or monthly	Monthly
All members of team attend	Yes
Conference on special call	Possibly
Professionals from community attend?	Sometimes

COMMUNITY CHARACTERISTICS	
Economic status	See
Ethnic composition	text
POPULATION SERVED BY PROGRAM	
All from surrounding community	See
Economic status	text
Ethnic composition	
Patient population not selected by center	
Special catchment	
COMMUNITY RESOURCES	
Day Care Center 24 Hours	No
Crisis Nursery	No
Foster Home	No
Therapeutic foster home	No
Hotline	No
Parent Aides	No
Parents Anonymous or other self-help group	No
Homemaker	--
Other, as Public Health Nurse	Yes
If available, would you use all or most of these?	
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	No
Does it relate with hospital team?	
EDUCATION	
In Community — by public	University courses
In Hospital	Some
School of Medicine, Law, Nursing	Yes
Public schools	–
Police Department	–
Other (state) Media, radio	Some
PROTECTIVE SERVICES	
Hospital and Community cooperate	Yes
Can child be held without parents' consent?	See text
CRITERIA for considering home "safe" developed with hospital participation	No
REPORTING mandated?	Yes
Abuse reports — by Team or individual?	Team
Report sent to:	DSS
Investigated by:	
Neglect reports — by Team or individual?	Same
Report sent to:	
Investigated by:	
Reporting procedure weekends, holidays, 24 hours?	–
Parents informed of reporting?	Yes
REGISTRY — in hospital	Yes
Central registry in state or community	No
Is central registry effective?	–
Can it be used by CA/N team?	–
Can confidence be expunged from record?	No
DISPOSITION	
Joint decision by team and protective service	Unknown.
Conference with family before disposition hearing	Decisions
% returned home	made
% returned home under protective custody	by local
% referred to Foster Care	agency.
% termination of parental rights	Sometimes
Any team members involved in court hearings?	
GUIDELINES AND CRITERIA	
for Abuse — written? unwritten, flexible on individual basis	On
for Neglect — written? unwritten, flexible on individual basis	indi-
Established criteria for considering home "safe"	vidu-
	al basis
PROFILE OF ABUSER	
Alcohol a factor in abuse	No
Drugs a factor in abuse	No
	No
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	No
Surveillance of newborns in abusive family?	No
Observation by obstetrical nurses?	No
Identification of "high risk" mothers in prenatal clinics?	No
FAMILY COUNSELING?	
Family planning recommended?	Yes
RESEARCH — ongoing	No
New study or expansion of research planned	Yes

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SITE VISIT NO. 6

Children's Hospital, Los Angeles
February 6, 1974

The City, population 3 million, area 400 square miles and the County, population 7 million, area 700 square miles, of Los Angeles, form a checkerboard suburban community of 40 police jurisdictions, and fill a coastal plain between high mountains and the sea. An almost constant atmospheric inversion and the exclusive use of automobiles for transportation result in severe air pollution. Los Angeles is a major intellectual center in the western United States, and there is much light industry. White, Black, Indian, Spanish-speaking, and all economic and age groups are represented.

The Children's Hospital of Los Angeles is the largest private children's hospital in the west and southwest of the United States. It serves as primary resource for all social levels of about one quarter of Los Angeles and as a referral source for the south-western United States.

About 12,000 inpatients are cared for annually. There are 245 inpatient beds, and 41 specialty clinics. About 450 children visit the clinics daily. The hospital also includes a rehabilitation center with 25 beds. Children with inflicted injury or severe neglect may be housed here for their convalescence.

The area surrounding the hospital within 30 minutes driving time includes urban poverty and wealthy residential sections. The hospital's ambulatory services provide primary care for low income urban families, one half of whom are recipients of Aid for Dependent Children (AFDC or "Medi al"). This population, from which the majority of cases of child abuse come, is about 50% Anglo-Saxon and 50% minority groups. Children's Hospital, Los Angeles (CHLA) reports one fourth of the total hospital-based referrals of child abuse in Los Angeles County. Ninety percent of cases enter through the emergency room, with 7% being brought in by police and 1% through child welfare or social service department referrals. Private physicians' reports account for less than 1% of cases.

The Child Abuse and Neglect (CA/N) program of CHLA is known in Los Angeles as one of the two area CA/N programs, the other being in the Los Angeles County Medical Center. CHLA identifies and reports about 100 cases of abuse annually, and admits but usually does not report, about 100 cases of severe neglect annually. (The incidence of child abuse and neglect in Los Angeles County is 30/100,000 population.) Many less severe cases of neglect -- failure to thrive -- are neither admitted nor reported. Cases of sexual abuse are usually referred to designated hospitals for examination unless the child is also physically injured.

Children's Hospital, Los Angeles

All children brought to the hospital and suspected of abuse are seen by the trauma coordinator, James Apthorp, M.D., a pediatrician, who heads the team. If he determines that there is "NAI" (non-accidental injury), the case is reported under California law through law enforcement agencies, the parents are notified, and the child is put under protective custody until a detention hearing can be held to determine if sufficient evidence exists to warrant Juvenile Court action. If so, an adjudication hearing is scheduled to consider the evidence. If it is determined that the child is in fact in need of court supervision, a disposition hearing will follow within two weeks. In L. A. County, 90% of the NAI children judged to be in need of court supervision are placed out of the home.

When the hospital team feels there is sufficient evidence to stand up in court, the Department of Public Social Services (DPSS) is notified.

Neglect cases are usually reported not to law enforcement, but to the Department of Public Social Services (DPSS) for "protective service." This service, however, does not operate with the authority of the court and may be refused by the parents. The CHLA team's definition of neglect is failure to thrive, below the third percentile for height and weight and no evidence of organic disease.

The Child Abuse and Neglect team, in addition to Dr. Apthorp, consists of the Case Coordinator, Miss Audrey Halperin, M.S.W., James Kent, Ph. D., psychologist; Howard Hansen, M.D., psychiatrist; a second pediatrician who serves as a consultant in " failure to thrive" cases; a pediatric nurse; a research assistant ; two representatives of the Los Angeles County DPSS and a secretary. The entire team meets weekly for case conferences. The hospital abuse guidelines are attached.

Funding of the team is diverse. Ten percent of the director's salary is paid by the hospital, although the time actually spent by him on child abuse and neglect work exceeds 10%. The case coordinator is only 10% funded (by grant); the rest of her time is bootlegged from a clinic which she actually staffs one half day a week. The psychologist and secretary are 50% funded by grant; the nurse and research assistant each 25% , and the psychiatrist and pediatrician 10%. The DPSS workers are paid by this agency.

The Child Abuse and Neglect program at CHLA was the pioneer program in the Southwest, developing the registry concept and defining many characteristics of the abusing population. By 1973, it had become inadequate in many ways. Psychiatric services are insufficient to provide evaluation of families or adequate follow-up therapy; psychological services for evaluation are limited and for follow-up essentially absent. Many community resources are available; but coordination among them is poor. Assessing these resources sometimes requires a special knowledge of eligibility and procedural rules that simply is not available to most persons.

The DPSS is given the primary responsibility for arranging for follow-up care of parents and children, but does not have contract authority for psychotherapy. Thus each worker has to "freelance" in finding help for the families in her caseload, and she is too overburdened to supervise the families' efforts (or non-efforts) as closely as closely as these cases require. Therapists in private practice, accustomed to treating more motivated families, and specifically not accustomed to reaching out vigorously to see that parents keep appointments or to visit with them in their homes, frequently do not follow through when families don't keep their appointments. Day care programs are few, and those which do exist frequently serve special groups, e.g., multihandicapped, minority groups in a defined area, and are not available for the majority of child abuse cases. The relatively great distances in the area and the absence of public transportation exacerbate the problems of follow-up and long-term treatment, so that up to now few cases have been followed at the hospital following initial disposition. As a result, most of the cases adjudicated as child abuse in the juvenile court are resolved by putting children into foster care. Because only about one-third of the families receive counseling or therapy of any kind, the conditions which made the home environment abuse-prone continue to exist. Thus, the children continue in foster care for lengthy periods of time; 40% of the children currently in foster care for reasons of abuse have been there for over three years.

The hospital's role in all of this is problematic. It continues with an aggressive case-finding and reporting program, but has psychotherapeutic resources adequate to see only a small portion of its reported cases after they have been through the judicial process. Compounding the problem is the tortuous bureaucratic, legal, and welfare maze which "serves" the child abuse cases. The family is almost always continuously involved with somebody, but the "somebodies" are from different public sectors which communicate only sporadically, if at all, with each other.(A foster mother with several children may have several different caseworkers.) As a family passes through the maze, it is often lost to follow-up by the agency which initiated the report. The problem is not one of indifference or individual incompetence, but of a massive system geared up primarily to protect but hardly at all to treat. Coordination and a redefinition of goals are sorely needed.

The Los Angeles Police Department has begun this effort. Recognizing that more children with problems are known to the police than any other agency, and that they are the only community agency with 24-hour field services, in 1970 they instructed a policewoman investigator assigned to the Juvenile Division to establish an Abused and Battered Child Desk within the Juvenile Division. In January 1974 the Child Abuse Unit was formally established in that Division. A change in California law, effective January 1974, will result in primary reporting of child abuse to protective services. In turn, they must then report to the police if there is evidence that a crime has been committed, e.g., the child sustained a physical injury.

Children's Hospital, Los Angeles

The police investigate each case and may "arrest" the child for protective custody. The trained city police are gradually teaching their skills to other police jurisdictions of Los Angeles County. Ms. Jackie Howell of the Los Angeles Police Department (LAPD) has been creative in developing the plan of investigation and follow-up of child abuse reports now in action. The Unit has five teams of two people, plus two other people assigned to the duty of investigating abuse reports. Ms. Howell has accented the necessity for constant education and special training for people involved in the abuse area. One serious problem is that there are 40 different police jursdictions in L.A. County. The LAPD is assuming a consultation advisory role concerning the establishment of coordinated child abuse teams in the other jurisdictions. The ten persons on the team receive constant training in the special needs of child abuse cases, particularly the importance of a non-punitive attitude toward the parents. Within one month of operation, the caseload was four times greater than expected. It is clear that this team is going to have to be expanded.

Psychological help to CA/N families is not routinely available through the CHLA program. However, there is the possibility of referral of parents to Parents Anonymous and Friends of the Family groups and Regional Mental Health Centers. Parents Anonymous is open to men and women, together or alone. They meet weekly for group therapy; additionally, the telephone is used for individual support. Attendance varies from one to nine or ten. Anonymity is maintained. Parents Anonymous was founded by "Jolly K" and is an independent group, but will be working with Children's Hospital staff in the new study.

In general, the relationship between the hospital, DPSS, and law enforcement agencies is good. Juvenile Court Judge Julius Liebow has begun to work with other professionals and the National Juvenile Justice System to determine the objectives of child abuse efforts and how to implement the objectives. In the past, there has been prolonged reliance on court action and out-of-home placement for Los Angeles County.

DPSS wishes to change the focus and effectiveness of intervention by participating with Children's Hospital in follow-up studies of the children in their care and has recently assigned two full-time workers to the hospital to centralize disposition and treatment functions.

Under a five-year Federal grant, the CHLA began in January 1974 to implement a new CA/N program: A Longitudinal Study of Physically Abused Children." This grant study will permit an expanded program which had just begun to function at the time of the site visit. Among other changes, the public social service role, previously divided between three or four workers, will now be performed by two full time hospital-based Los Angeles County DPSS workers, additional workers being assigned if needed. In addition to providing increased personnel for more adequate in-hospital intervention and investigation, more rapid and objective decisions regarding placement disposition, more effective

treatment programs for parents, and more complete and integrated social service follow-up and treatment, the new program will also involve a control group and an experimental group. The defined control group will be studied in coordination with as closely similar as possible study and experimental CA/N groups at the Kauikeolani Children's Hospital and the Children's Hospital Medical Center, Boston.

The entire community: public, police, social services, community services, schools, and professionals, are, or will be, responding to this change. Through state-wide participation in studies and discussions, the program leaders in CHLA and in the LAPD are changing the CA/N reporting laws and programs in California.

SUMMARY

The CA/N program at the Children's Hospital of Los Angeles is just moving, as of the site visit date, from the pioneer, traditional, and overloaded diagnostic and dispositional approach to a multidisciplinary, community-wide and extra-community collaborative therapeutic and controlled investigative program.

Additional information on file at the Academy office:

1. Questionnaire.

2. Site visit reports by individual team members: Dr. Bates, Dr. Steele, Ms. Tenne.

3. Syllabus and background information for Child Abuse Unit, Los Angeles Police Department. Unpublished manuscript.

CHILDREN'S HOSPITAL OF LOS ANGELES, CALIF.
HOSPITAL POLICY: SUSPECTED INFLICTED INJURIES

Recognition and appropriate action in the cases of infants with possible inflicted injuries may be life-saving. Because the diagnosis is not always clear-cut and because the actions required can be unpleasant for staff members, the following system of work-up and review will be observed whenever this diagnosis is entertained.

1. Consider the possibility of inflicted injury under these circumstances:

   a. Any fracture or significant soft tissue injury in an infant or young child when the history given is discrepant with the observed injuries.

   b. Any fracture in an infant that has not been walking unless clearly related to the birth process.

   c. Any serious soft tissue injury or burn in such an infant.

   d. Any fracture or serious soft tissue injury in an infant or child who also shows signs of neglect.

   e. Infants with subdural hematoma, or subarachnoid bleeding.

   f. Visible soft tissue injuries in any age child be reason of location and multiplicity, not likely to be accidental.

2. Work-up

   a. History

      At the earliest opportunity a detailed, pertinent history should be obtained. Histories of accidents must include the usual "when, where, who and how" and must be in sufficient detail for a judgment to be made as to whether or not the observed injuries can be explained.
      Detailed family and social histories are often useful, but may be obtained at convenience. Questions relevant to bleeding disorders, bone disease and nutrition are important. Positive or negative statements regarding prior injuries should be recorded.

   b. Physical Examination.

      Physicals must be done in detail and recorded with utmost care. All abnormal findings should be recorded as well as significant negative statements such as " no bruises ". No bony deformities", etc., as applicable. When consents have been signed photographs may be obtained if there are clear-cut visible signs which can be photographed. (often done by police investigators)

Hospital Policy: suspected abuse

c. Laboratory work

This is ordered as deemed necessary on an individual basis; however, studies of clotting mechanism are indicated where extensive bruising or intracranial hemorrhage are found.

d. X rays

Films appropriate to clinically suspected injuries should be obtained. In addition, skeletal surveys should be ordered. "Appropriate" x-rays will be charged to patients in the usual manner. Skeletal surveys will not be charged and in order to assure this requisitions ordering them should be identified "Trauma Study".
Since x-ray findings of bony injury become more evident after some healing, repeat studies at 7-14 day intervals are often useful.

e. Consultation

Consultation on patients at any stage of the evaluation may be obtained from the "Trauma consultant" or the Chief Resident. When the patient's condition is critical or when the family wishes to remove the patient from care, such consultation should be obtained immediately.

f. Diagnosis

The diagnostic impressions "unsuspected trauma", "inflicted injuries", "battered child syndrome", etc. should not be written on the charts until the case has been reviewed as described as follows.
Rather the impressions recorded initially should be essentially descriptive, e.g., "multiple chip fractures of both femurs and right humerus", or "skull fracture and multiple rib fractures", "multiple trauma".

g. Review

As soon as the basic diagnostic studies have been obtained, the case should be reviewed with the Trauma consultant.
The purpose of this review will be to attempt to establish a diagnosis, order further study as indicated, and to decide whether or not a police report must be made. At the same time a specific physician will be designated who will be responsible for assisting a police investigation and for giving testimony if required, usually senior resident on service.

Hospital Policy: suspected abuse

h. Patients admitted by attending staff physicians (continued)

The apparatus described above is available at the request of the attending physician. The resident's responsibility is to inform the attending physician of its availability and to inform the Trauma consultant; all major decisions will be the attending physician's responsibility.

i. Police reports

Reports to the police will normally be made by Medical Social Service, after medical review of the case as described above. In emergency situations reports may also be made by the Chief Resident. In all instances telephoned reports will be followed up by written ones signed by the senior resident, trauma consultant, Chief Resident, or attending physician on the service responsible for the patient. Non-Accidental Injury Report form will be filled out promptly by the senior resident on service and returned to the Chief Resident's secretary who types the written report.

j. The Trauma Consultant

The Trauma Consultant (s) will be designated by Childrens Hospital of Los Angeles. The name (s) will be posted in the Emergency Room on the Bulletin Board in the resident's office.

k. Advice

Physicians, social workers, nurses and other hospital personnel dealing with patients and families in which inflicted trauma is being considered must maintain a professional attitude at all times. Our task is to establish the medical facts and not to accuse, fix guilt, make judgments or punish. The probable veracity of a history as related to a set of injuries is clearly a medical judgment; the determination of guilt and the final assessment of safety or danger to an infant in a home is a legal judgment, based on evidence which is not always available to us. Do not allow parental attitudes or appearance to influence your diagnostic judgment. Do observe and record parental statements and actions, since these are facts which may bear on diagnosis.

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CHILDREN'S HOSPITAL OF LOS ANGELES
Los Angeles, California

Date & bases for establishment of CA/N program	1959
Location	Hospital
AUSPICES: Hospital, Medical School, Health Dept, other (explain)	Medical School
Medical School affiliation	Yes
FUNDING: Grant (type), public, private, state institution, other	Patient
Allotments if any for CA/N	HIMH #-
Funding restraints	Yes
Copy of budget attached	-
PATIENT STATISTICS	
# inpatients/year	14,000
# outpatients/year	160,000
# abused patients admitted/year	100
# abused patients treated in outpt dept/year	
# sexually abused/year	Few
# neglected/year	100
CA/N TEAM	
Composition & % of time in CA/N	
Head — Pediatrician	10
Coordinator — MSW	10
Hospital Administrator	0
Pediatrician — Consultant on FTT	10
Physician — (1) Psychiat. (1) Psychol	50
Surgeon	25
Nurse	100
Social Worker	0
Attorney	0
Other (state) — Secretary, 50%; Research Assts	50
Does Team see all suspected cases of abuse? neglect?	Ped. Hosp
Are there written, procedural guidelines for Team?	No
Who developed them?	Yes Hosp. staff
PATIENT FLOW	
Intake — % through Emergency Room	90
% through Pediatric Clinics & Wards	1
% through Child Welfare Social Service	1
% through neighbor report	0
% through private physician	1
% through parental call for help	0
% through police	7
% through school	0
% Other (state)	-
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological history?	Yes
Family profile? (Information on sibs and parents)	Yes
DIAGNOSIS - IDENTIFICATION	
By CA/N Team according to established criteria	Yes
By individual physician or ER staff	
Previously identified and sent to center for confirmation and treatment	
TREATMENT	
24 hr medical/surgical treatment available	Yes
Psychological service	Some
EVALUATION of child	
for emotional disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS?	Yes
Evaluation of SIBLINGS?	Yes
REHABILITATION	
Medical/surgical	See
Psychological	text
Short term rehabilitation	
Long term rehabilitation	
Referral to other treatment center	
If return appointments are not kept, is there follow up and by whom?	
COST OF PATIENT CARE	Daily
Delineated for Treatment, Evaluation, Rehabilitation	Range
	50/150
FOLLOW UP	Poor
Is there feedback to program from Protective Services?	
CASE CONFERENCES - in facility	Weekly
Held regularly, weekly or monthly	
All members of team attend	Yes
Conference on special call	Monthly
Professionals from community attend?	Yes

James Apthorp, M.D.
Director - C/N program

COMMUNITY CHARACTERISTICS	
Relationship of surrounding health facility	See text
Ethnic composition	
POPULATION SERVED BY PROGRAM	
Catchment area	See text
Economic status	
Other characteristics	
Number of patients seen/year by center	
Area of coverage	
COMMUNITY RESOURCES	
Day Care Center (24 hour)	No
Crisis Nursery	No
Foster Home	Yes
Therapeutic foster home	Yes
Shelter	Yes
Group Home	No
Parents Anonymous or other self-help group	Yes
Homemaker	Yes
Other, as Public Health Nurse	-
If available, would you use all or most of these?	Yes
IS THERE A CHILD ABUSE COUNCIL OR COMMITTEE?	Being org.
Does it relate with local team?	
EDUCATION	
Of Community - by public through news	Yes
Hospital	Yes
School of medicine - lay nursing	No
Other agencies	Yes
Police Department	Yes
Other (state)	-
PROTECTIVE SERVICES	
Hospital and Community cooperate	Yes
Can child be held without parents' consent?	By police
CRITERIA for considering home "safe" developed with hospital participation	No
REPORTING mandated?	Yes
Abuse reports - by Team or individual?	Coordin.
Report sent to	Police
Investigated by	
Neglect reports - by Team or individual?	Ind.
Report sent to	to DSS
Investigated by	
Reporting procedure weekends, holidays, 24 hours?	Yes
Parents informed of reporting?	Yes
REGISTRY - in hospital	Yes
Central registry in state or community	No
Is central registry effective?	-
Can it be used by CA/N team?	
Is information received prompt?	No
COURTS	
Joint decision by team and protective service	No
Conference with family before disposition hearing	Yes
% returned home	7
% returned home under protective custody - Relative	24
% referred to Foster Care	63
% termination of parental rights	7
Any team members involved in court hearings?	Sometimes
GUIDELINES AND CRITERIA	
for Abuse - written? unwritten, flexible on individual basis	Written, flexible
for Neglect - written? unwritten, flexible on individual basis	
Established criteria for considering home "safe"	DPSS
PROFILE OF ABUSER — Mother, father, stepparent	
Alcohol a factor in abuse	Slight
Drugs a factor in abuse	factor
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	No
Surveillance of newborns or abusive family?	Sometimes
Observations by obstetric nurses?	No
Identification of "high risk" patients in prenatal clinics?	No
FAMILY COUNSELING?	Yes
Family planning recommended?	Not routinely
RESEARCH - ongoing	Yes
Is a study or evaluation of research planned	Yes

SITE VISIT NO. 7

New York Foundling Hospital
New York City, New York
January 4, 1974

New York City, population 8,000,000, is the center of the largest megalopolis in the United States. Seventeen thousand cases of abuse and neglect were reported in 1973, 3,500 of physical abuse. About one-half, or 1,800, occurred in Manhattan and the Bronx, catchment boroughs for the New York Foundling Hospital. Of the 1,800 cases, 38 cases (families) were treated in the New York Foundling Hospital. There is no comparable service for the remaining 1,700 or so cases.

The New York Foundling Hospital child abuse program was developed following publication of the report of the Mayor's Task Force on Child Abuse, which was chaired by Vincent J. Fontana, M.D. The Task Force in its final report published in 1970 said:

"There is no consistent, city-wide psychiatric service currently available that specifically deals with abusive parents."

In an effort partially to fill this need, the program was instituted in October, 1972 to treat abusing and neglectful parents in a comprehensive manner on an in- and out-patient basis. Families are selected by the Bureau of Child Welfare, the Courts, and medical facilities, according to criteria which include need and urgency. To be eligible for residence, the mothers must be over 16, indigent, and cannot have over two children. Larger families are treated on an outpatient basis.

Although it has an emergency room where abusing parents can present themselves for intervention, the New York Foundling Hospital is more an hospice or shelter than a hospital in the currently accepted sense. Cases of child abuse selected for treatment are admitted after initial diagnosis and treatment elsewhere. The mother and her one or two children (no fathers) come in and live in the hospital. Here they receive superb and expensive treatment: annual budget $280,000 or about $7,000 per mother-child unit.

50% of the mother-child families treated to date are black, 35% Spanish in origin, and the rest are white. The age of the mothers ranges from 17 - 28, the average 22. Only one of the mothers has completed high school. In I.Q. they range from 59 to 114. Every mother seen but one has experienced abuse in her own childhood. The mothers live in eight private rooms on one floor of a wing of the "hospital", and share their room with their child. On the floor at all times is one of four paraprofessionals. These are women who have been trained by a social worker, but are not academic types; rather, they are chosen so that the mothers may identify with them. They may have been on welfare themselves;they may be black or Puerto Rican.

New York Foundling Hospital

They are given two weeks of orientation, after which they are assigned to a social worker for 2-3 months training. When the mother is discharged from the residential, or in-patient, part of the program to go to an apartment, the paraprofessional and social worker continue to see her on home visits.

Before admission, the mothers are screened by a psychiatrist and a social worker, and if admitted are accompanied by the Protective Services social worker. During the residential part of the treatment, the patient receives psychiatric treatment in group as well as private sessions. There is a paraprofessional group mother on the ward, in addition to the paraprofessionals already described. On admission, a Social Service Assistant is assigned to a mother and continues to work with her during treatment and when she returns to the community. If a mother does not progress enough to go home with her child, the child may be sent away for foster care. In 30-35% of the Foundling cases, the children had to be temporarily removed from the mother at some point.

While in residence, the mothers are free to come and go on the ward, except that they are expected to participate in the therapy appointments set up for them. (See instructions given to the mother on admission, attached). They are expected to keep their rooms and selves and children tidy, to help shop and prepare meals, and to care for their infants. They are given $20 monthly for clothing and a modest food allowance. The principle underlying the program is that a meaningful, accepting relationship must be established if the mothers are to be rehabilitated. The relationship is the more difficult because abusing parents characteristically build a wall between themselves and those attempting to help them. During three months of in-patient treatment, many professional and paraprofessional people reach out to help the mothers. If the relationship is successful, there is an opportunity to prevent further abuse or neglect, and break the vicious cycle of abuse from generation to generation.

The initial workup is usually followed by a period of resistance, since the regulations are not unlike those of a convent school. After two or three weeks a warm relationship between patient and staff begins to develop. Treatment is intense, supervision close. The patients soon play important roles in the therapy of other patients, and in decisions about and operation of the program itself. As progress occurs in relating to their children, mothers are allowed to go home on weekends. After three months, mothers are usually well enough to be discharged to their own homes - which they have usually kept during their stay at the Foundling. A 12-month supervised period follows, with thrice weekly home visits by lay Parent Assistants, and twice weekly visits to therapy sessions in the hospital. It appears that families are then "on their own", as the three times a week visit by the parent assistant stops; however, contact with the Bureau of Child Welfare workers continues.

New York Foundling Hospital

There is also a hot line to the hospital; and a continuous relationship with the New York Foundling Hospital social worker assistants and other mothers in the program is stated to occur.

The New York Foundling Hospital is related to an acute hospital, namely, St. Vincent's Hospital and Medical Center of New York. Both institutions are run by the Sisters of Charity; and the Medical Director of the New York Foundling Hospital, Dr. Fontana, was formerly Director of Pediatrics at St. Vincent's Hospital. The pediatric residents at St. Vincent's Hospital work nights covering the nurseries at the New York Foundling Hospital. There is a regular program of teaching for residents and interns at St. Vincent's Hospital. The Medical Director is also Professor of clinical Pediatrics at New York University College of Medicine.

The Foundling Hospital program is funded through Federal, state and city grants and foundation monies. The team is headed by Dr. Fontana. Patrick Bologna, S.C.W., A.C.S.W., is the coordinator. The rest of the team consists of a sociologist, a psychiatrist, psychiatric social worker, social service assistants, a psychometrician, group mothers, a secretary, a supervisory housemother, and a housekeeper. All or most of the team meets weekly for conferences on patient progress. There are also group therapy meetings twice a week. Individual professional psychotherapy is less frequent.

To date, of the mothers who have "graduated", two were recidivists.

It is important to place this program in the perspective of the progress of the City of New York in child abuse and neglect activities. New York City had no city child abuse office until 1964, when the Bureau of Child Welfare opened the first borough office with six workers. Now there are 300, and there is also a New York State and City Central Registry for child abuse.

In 1968, Mayor Lindsay set up a Task Force on Child Abuse and asked Dr. Fontana to chair it. The Task Force was asked to study the effectiveness of existing programs for the reporting and follow-up of abused and neglected children, the availability of foster homes, and other custodial facilities in the community to provide care for the child at risk, the availability of psychiatric care, and other services for the rehabilitation of the emotionally disturbed parents of maltreated children, and the adequacy of educational programs to enable health professionals, social workers and legal authorities to deal with the problems of child abuse and neglect. After completing the study, the Task Force was asked to make recommendations.

In 1971, the first Task Force report was given to the Mayor who established a new, centralized Emergency Children's Service to receive all reports of suspected child abuse and neglect, 24 hours a day, to be operated by the Interagency Council on Child Welfare and the welfare department.

New York Foundling Hospital

In 1973, New York State enacted the Child Protective Services Act. Among other provisions, this act expanded the registry statewide, included neglect as well as abuse, and set penalties for failure of mandated persons to report cases to the registry.

In the city, reports of child abuse are investigated by the Bureau of Child Welfare. After investigation, a decision is made by the Bureau as to whether the abused child stays home. If so,the family is referred to a caseworker in Preventive Services. Group therapy is available for mothers, older children and adolescents; however, there are only four or five psychologists for the city, and they work largely on a consultant basis. One or two psychiatrists are similarly used as consultants. The Bureau may use the city mental hygiene clinics, or a psychiatrist paid by Medicaid. In problem cases, the Bureau may refer a mother for admission to the New York Foundling Hospital program. It is apparent, however, that the therapeutic resources available to so large a city are sadly limited.

SUMMARY

Clearly, the City of New York has a long way to go to combat one of the findings of the Select Committee on Child Abuse: "Abused and Neglected Children are in Urgent Need of Therapeutic Services." (Report of the Select Committee on Child Abuse, New York State Assembly, p. 73, April, 1972.) The Foundling Hospital Program, although treating only a small, selected minority of cases in a large and socially over-burdened city, is setting an example of excellence: in the innovation and thoroughness of its approach, and in its commitment to the changing of deep-seated behavior patterns as the best basis for halting child abuse. This program obviously is not the answer to the 20,000 cases of child abuse and neglect reported annually in New York City. The team is working with city and community agencies on projects for early detection and prevention of child abuse. Future plans include the establishment of satellite centers in Community Child Health Stations and Family Health Centers to screen and "diagnose", treat and prevent child abuse. This may be the real role of the Foundling Hospital; a training and teaching center in preventive and therapeutic techniques in the area of child maltreatment.

Additional information on file at the Academy office:

1. Questionnaire.

2. Site visit reports by individual team members: Dr. Bates, Dr. Lockhart, Dr. Mindlin, Ms. Tenne.

3. Operating manual for temporary shelter, including job descriptions, philosophy, instructions to mothers (attached).

4. Report of the Select Committee on Child Abuse, New York State Assembly. April 1972. (Report No. 1)

5. A Court in Crisis: The New Yirk City Family Court-September 1972. Study Report No. 2, Select Committee on Child Abuse, N.Y. State Assembly.

NEW YORK FOUNDLING HOSPITAL

Information for Mothers

INTRODUCTION

This program has been designed to help you to care for your children by participating in both educational and therapy programs. Most importantly, it is an opportunity for you to care for your child with the assistance of trained personnel, people who are genuinely interested in helping both yourselves and your child. It will also give you the opportunity to help one another since allof you will be part of the same program and will greatly affect each others lives.

Since each of you will be living together with your child, it is obvious that only by working together in a cooperative way can your stay here be a pleasant and meaningful one for both yourselves and your child. As in any cooperative living arrangement, it is important that guidelines be established for each person so that everyone will take on responsibilities that are both essential to yourselves and your child. This manual was written to help you understand what these guidelines are so that there will be no confusion regarding areas of responsibilities for each resident. Since this program was designed to help you, it is important that you participate actively in all group discussions concerning the program. In doing this, you will have the opportunity to make a contribution to the program which will help yourself, your child and each other participate in the program.

HOUSEHOLD RESPONSIBILITIES:

Among the most important areas of responsibilities are those which will help you to learn new and different approaches to caring for your child and home when you return. Each participant in the program is required to actively take part in caring for the house for three basic reasons - one, it is kept clean for both yourselves and your child's health, two, when you return home you will have added knowledge about housekeeping and cooking responsibilities and three, the most important reason, your child will grow up learning from your example the importance of cleanliness.

For the above reasons, each participant is expected to do the following:

1. Keep her room clean and make bed every morning upon rising.

Information for Mothers (Continued)

2. Participate in cleaning all other areas of the house. The Group Mother will assign different responsibilities on a rotating basis.

3. Participate in the preparation of all meals with the assistance of the Group Mother.

4. Serve meals and clean up after each meal. This will also be arranged on a rotating basis, by the group mother.

Many of the courses you will be taking are directly related to the above areas of responsibilities. These activities should therefore be seen as an opportunity to put into practice what you have learned.

PURCHASING ITEMS:

One aspect of our program will deal with consumer education to provide you with an opportunity to determine the quality of products you will be purchasing in caring for your family.

The following responsibilities are designed to help you put into practice what you have learned in consumer education:

1. Each mother will be responsibile for purchasing her own clothing as well as clothing for her child. A staff member will be available to help you as needed.

2. On certain occasions food items will be purchased directly from the community. Each participant will have an opportunity to take part in this along with planning the menu.

ALLOWANCES:

Since it is important that each mother be able to budget money according to her financial income and material needs, allowances will give you an opportunity to plan ahead for yourself. Clothing allowances will give you an opportunity to plan ahead for yourself and your child.

CURFEW:

Although we realize that it is hard to plan time on an evening out, and that probably most of you have had considerable freedom deciding your hours on your own, we must ask that you report back at a specified time. While you are staying with us

Information for Mothers (Continued)

we ask you be in at 11:00 P.M. on your weeknight out and 1:00 A.M. on weekends. This is a means for us to keep track of you as well as an expression of concern for your welfare. If returning at the specified time is impossible due to either transportation, etc., please notify the Group Mother on duty as soon as you know you will be late by calling:

Thus the curfew hours are:
11:00 weekdays
1:00 A.M. Friday & Saturday
9:00 P.M. Sunday

Hours can be adjusted according to the individual situation of the resident, and her progress in the Program.

WEEKEND VISITING:

We encourage you to keep active contact with family and friends and we hope that that our program will help you to get along even better with them. Thus, weekend all-day visiting is permitted from 9:00 A.M. (or after breakfast) until 8:00 P.M. or earlier depending upon your baby's schedule. We ask you to be back then so your child can be put to bed. These visits will be cleared with the psychiatric social worker whose approval you need to visit out. This is because some of you may be having various problems at home or here at the Residence and a visit home may not be the best thing for you or your child at this time. As you stay on in the program, and prove that the visits are helpful and that you can return on time, then overnights can be arranged.

VISITORS:

As was stated before, this program wishes to strengthen your friendship and family ties and thus we encourage visiting. However, we ask that you receive visitors at certain times so as to not make it uncomfortable for the other residents, and so we can keep in touch with who is on the floor. You can receive visitors two evenings during the week on an evening when you do not have any scheduled activities from 7:30 to 9:00 P.M. This will be cleared with the psychiatric social worker who will arrange and schedule visitors. If you are not visiting out on weekends you can have vistors Saturday and Sunday between the hours of 1:30 to 5:00 P.M. and 7:30 to 9:00 P.M. at night.

I am sure that you will enjoy your visitors and want to speak with them privately, but you may also want to include some of the other residents in on your visits and share your friends and family. On Saturday evening, the residents who are staying

Information for Mothers (Continued)

in can cook or fix something special, and put on a little party for family, friends, and fellows residents together in the lounge. Coffee, soda, or maybe a special punch could be served for refreshments.

ATTENDANCE IN PROGRAM ACTIVITIES:

Every activity in your daily schedule is designed to help you in a different way. For example, certain groups are to eat breakfast together every day at a specific time. This may seem strict to you, but we feel that it is important to make close ties as a group and we do this by sharing common everyday experiences. Thus, when you first arrive at the residence, a daily schedule will be given to you with all of the activities that you and your child are to participate in. Attendance in all of these activities ranging from meals to group therapy is necessary in order that our program will be of benefit to you and child. Some of the activities you will enjoy more than others or will feel more helpful, but please remember that participation in all of the different activities will eventually help you the most.

After you are here for a while, we would like very much for you to discuss your feelings about the program and listen to your suggestions. You will be given many opportunities in groups and individually with your therapist, to make suggestions or revisions in the program.

CHILD CARE:

Although the Group Mothers are here to help you look after the children the ultimate responsibility for your child belongs to you. This program was designed so that you and your child would not have to be separated and also to assist you in difficulties you may be having with family, friends, or your child. To help you handle these problems more easily, we are all here to help each other.

While you are engaged in your activities, the group mother will look after your child along with the assistance of one or two other mothers. You will be assigned to help the group mother on regular basis according to your schedule.

During mealtime, you are responsible for feeding your own child who will be with you. We have tried to arrange for you to feed and dress your child, and do many of the things that you normally do. However, if you are goint to be very busy or would like a little rest, you can ask another resident to "babysit" for you, and then at another time babysit for her. We encourage this kind of sharing of responsibilities. Just check with the group

Information for the Mother (Continued)

mother who is to decide if permission is given.

Because of your responsibility to your child and his young age, we must know your general whereabouts at all times. When you leave the floor, be sure to sign our and check with the group mother.

PARTICIPANTS WHO ARE LIVING AT HOME:

Although you are living at home, we do expect you and your child to participate in the program fully along with the resident mothers. We ask this as we want the program to help you and your child and also want you to feel just as much a part of the residence as the women and children who live here. If you are ill or something has happened to prevent you and child from coming in on time or at all, then call the group mother as soon as you know.

ASSORTED RULES & REGULATIONS

1. No alcohol or drugs on premises
2. There will be always be food in the kitchen for a snack, so please no food in bedrooms.
3. You will be provided with identification cards which you should carry when you leave the floor.
4. Sign you name and where you are going in the sign out book on the table next to the lounge. Let the group mother know you are leaving.
5. We certainly want you to have your privacy but please do not keep your doors locked. If you want to take a nap or wish some time to yourself, we will have little signs to put on your door indicating that you do not wish to be disturbed. Thus, you do not have to use the locks on your door. If you see that someone is sleeping or wants to be alone, please respect their wishes.

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TEMPORARY SHELTER, NEW YORK FOUNDLING HOSPITAL
New York, N. Y.

Vincent J. Fontana, M.D.
Director

Date & basis for establishment of CA/N program:	8/74
Location	Foundling Hosp.
AUSPICES: Hospital, Medical School, Health Dept., Other (explain)	Child care agency
Medical School affiliation	No
FUNDING: Grant (fed., public, private, state institution, other	Govt. & private foundation
Allotments if any, for CA/N	
Funding restraints	
Copy of budget attached	See text
PATIENT STATISTICS	
# inpatients/year	35
# outpatients/year	6
# abused patients admitted/year	35
# abused patients treated in outpt dept/year	6
# sexually abused/year	0
# neglected/year	35
CA/N TEAM	
Composition & % of time in CA/N	
Head — Pediatrician	50
Coordinator — MSW	100
Hospital Administrator	-
Pediatrician — Psychiatrist	40
Physician — Psychologist	40
Surgeon	-
Nurse	-
Social Worker	100
Attorney — Secretary	100
Other (state) — Sociologist	60
Does Team see all suspected cases of abuse?	Yes
" " " " " " " neglect?	Yes
Are there written, procedural guidelines for Team?	Yes
Who developed them?	Team
PATIENT FLOW	
Intake – % through Emergency Room	50
% through Pediatric Clinics & Wards	-
% through Child Welfare Social Service	25
% through neighbor report	-
% through private physician	-
% through parental call for help	25
% through police	-
% through school	-
% Other (state)	
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological history?	Yes
Family profile? (Information on sibs and parents)	Yes
DIAGNOSIS - IDENTIFICATION	
By CA/N team according to established criteria	
By individual physician or ER staff	
Previously identified and sent to center for confirmation and treatment	Yes
TREATMENT	
24 hr medical/surgical treatment available	Yes
Psychological service	Yes
EVALUATION of child	
for emotional disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS?	Yes
Evaluation of SIBLINGS?	Yes
REHABILITATION	
Medical/surgical	Yes
Psychological	Yes
Short-term rehabilitation	Yes
Long-term rehabilitation	Yes
Referral to other treatment center	Yes
If return appointments are not kept, is there follow-up and by whom?	Social w.
COST OF PATIENT CARE	
Determined for Treatment, Evaluation, Rehabilitation	7,000 yr unit
FOLLOW UP	
Is there feedback to program from Protective Services?	See text
CASE CONFERENCES – in facility	Weekly +
Held regularly, weekly or monthly	Yes
All members of team attend	Yes
Conference on special call	
Professionals from community attend?	No

COMMUNITY CHARACTERISTICS	See text
Boundaries for population surrounding health facility	
Economic class	
Ethnic composition	
POPULATION SERVED BY PROGRAM	See text
All from surrounding community	
Economic status	
Ethnic composition	
Patient population not selected by center	
Special category	
COMMUNITY RESOURCES	
Day Care Center/24 Hours	Yes
Crisis Nursery	Yes
Foster Home	Yes
Therapeutic foster home	No
Hotline	Yes
Parent Aides	Yes
Parents Anonymous or other self-help group	Yes
Homemaker	-
Other, as Public Health Nurse	-
If available, would you use all or most of these?	Yes
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	
Does it relate with hospital team?	No
EDUCATION	
in Community – lay public	Yes
in Hospitals — Staff informed	Yes
School of Medicine, Nursing	Yes
Public schools	Yes
Police Department	-
Other (state) — Health Department	
PROTECTIVE SERVICES	
Hospital and Community cooperate	No
Can child be held without parents' consent?	By court order
CRITERIA for considering home "safe" developed with hospital participation	--
REPORTING mandated?	Yes
Abuse reports – by Team or individual?	All cases previously reported
Report sent to:	
Investigated by:	
Neglect reports – by Team or individual?	
Report sent to:	
Investigated by:	
Reporting procedure weekends, holidays, 24 hours?	
Parents informed of reporting?	
REGISTRY – in hospital	Yes
Central registry in state or community	Yes
Is central registry effective?	Yes
Can it be used by CA/N team?	Yes
Can complaint be expunged from record?	
DISPOSITION	
Joint decision by team and protective service	Yes
Conference with family before disposition hearing	See text
% returned home	
% returned home under protective custody	
% referred to Foster Care	
% termination of parental rights	
Any team members involved in court hearings?	Sometimes
GUIDELINES AND CRITERIA	
for Abuse – written? unwritten, flexible on individual basis	Written
for Neglect – written? unwritten, flexible on individual basis	Written
Established criteria for considering home "safe"	Yes
PROFILE OF ABUSER	
Alcohol a factor in abuse	Yes, see text
Drugs a factor in abuse	
NEW CASE FINDING – PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	Does not apply.
Surveillance of newborns in abusive family?	
Observations by obstetrical nurses?	
Identification of "high risk" mothers in prenatal clinics?	
FAMILY COUNSELING?	
Family planning recommended?	Yes
	Yes
RESEARCH – ongoing	Yes
New study or expansion of research planned	Yes

SITE VISIT NO. 8

Children's Hospital of Pittsburgh
Pittsburgh, Pennsylvania
January 3, 1974

Pittsburgh, population 520,000, is located in the steep valleyed and deep rivered Allegheny Mountains, an area alternately intensely urban and isolated rural. The Children's Hospital is the principal hospital for children, and serves through its outpatient departments the quotidian needs of the urban indigent. Non-indigent outpatients are usually physician referred. Inpatient services (200 beds) serve both rich and poor in the tri-state area of southwestern Pennsylvania, eastern Ohio and northwestern West Virginia. In reality, only 10% of admissions are out of state and most come from western Pennsylvania.

The child abuse program in Children's Hospital, founded over 10 years ago and gradually developed since then, serves an unusually stable population including numerous ethnic groups which mingle or migrate relatively little. There is no special funding. The coordinator is paid by the Poison Control Center, a dual role which may contribute to the vitality of the program and the awareness of the hospital staff. The Director, Dr. John B. Reinhart, is in the same vein, professor both of Pediatrics -- taking his turn as attending physician on the wards -- and Psychiatry.

Children's Hospital has an annual admission rate of 9500 patients, and last year there were over 100,000 outpatient visits. It is estimated that roughly 1.09% of these children were treated for abuse. Suspected cases of child abuse (not including sexual or neglect) reported from Children's Hospital annually under the mandatory Pennsylvania State law have increased as shown:

1971 - 59 cases
1972 - 72 cases
1973 - 90 cases (15 of these were outpatient)

The reports are made orally to Child Welfare and are followed in 48 hours by a written report. The law grants immunity to the physician, nurse, teacher, or other reporter. In addition to these reports, cases where abuse is believed potential are referred to local Child Welfare service for protective casework; such reports may total over 100 annually.

All admissions at the Children's Hospital are reviewed by social service workers, who are alert to possible child abuse. The hospital has a 250-bed capacity, a house staff of 100 (50 of whom are surgical) and 26 plus social service workers, of whom 11 do child abuse work. The Department of Public Welfare has assigned a full-time social worker for Children's Hospital. Seven nurses work exclusively for the Poison Control Center, and these nurses are alert to child abuse problems and report suspicions to the SCAN ("Suspected Child Abuse and Neglect") group. A SCAN consultation "team" sees all hospitalized children where abuse is suspected. In 1973, of the 150 cases of CA reported in Allegheny County, 90 came from the Children's Hospital, about 25 from the regional hospitals, the rest from schools and other hospitals.

Children's Hospital of Pittsburgh

Of the child abuse cases seen in 1972 at the hospital, 32% were cases of abuse, 41% neglect, and 15% both. More than half were infants under age two. Intake into the program is through emergency room 75%;welfare services, 10%, neighbors less than 10%, police 5%, schools 5%, parental call for help less than 1%,and physicians less than 1%. The child abuse program at Children's Hospital has a high visibility in a large and busy institution. There are 30 social workers in the clinic alone; and all emergency room records, all admissions and sibling records, are reviewed for possible abuse. The high risk obstetric service is also monitored for prevention, and social services follow all mothers, even non-high risk.

As yet, Pittsburgh has no hot line or parents anonymous.

Children's Hospital, which is part of the University of Pittsburgh Medical Complex, is the training facility for all medical disciplines in pediatrics. The hospital keeps all records of all reported abuse cases found at the Children's Hospital or at one of the localized pediatric regional units in other hospitals in the city. Such patient charts are marked with a large red "SCAN" which serves as an alert at the next medical visit of that child or a sibling. The hospital registry works well, but there is no central registry. A city registry, once successfully opposed by the ACLU, is under discussion again. The hospital registry informally serves the city at the present time.

The aggressive, warm, and ubiquitous nature of the child abuse programs seen at other successful sits is present here in the Children's Hospital. Charts stamped in red with "SCAN" are seen here and there on racks and nursing stations reminding staff of the presence of suspected abuse wherever they turn.

The SCAN team meets at any time and weekly, and sees all children suspected of abuse. The coordinator, Sue Evans, M.S.W., is young and vigorous. Other members include a full-time Department of Public Welfare social worker who acts as liaison between hospital and DPW, the hospital's chief social worker who is also the clinic's chief psychiatric social worker, the director of the Poison Control Center (who is interested in possible relation between poisoning and abuse,) and the chief psychologist.

The diagnostic criteria and procedures of the program are attached.

Systematic minutes of team conferences are not available at meetings. Intake workup is thorough. Acute care facilities in hospital are excellent, as are outpatient services and medicine, surgery, psychiatry, and psychology. Family dynamics in child abuse were originally described at Children's Hospital by Elmer *, and the present program is struggling to continue and improve follow-up on the increasing patient load. For this, increased funding will be needed.

The vigorous and aggressive hospital program contrasts with spotty but increasing community services and incomplete but growing community support. For lack of a crisis nursery, crisis admissions are made to the hospital.

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*Elmer, Elizabeth: Children in Jeopardy: a study of abused children and their families. Univ. of Pittsburgh Press, 1967.

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Children's Hospital of Pittsburgh

Social services have been considered by the hospital to have problems in carrying out their responsibilities. However, DPW hospital staff work together more and more to arrive at mutual understanding on cases of abuse.

Day care services do not exist. There are not enough foster homes and no parent aide programs.

The Pittsburgh Children's Hospital program appears unusually well related to the courts, and the juvenile court judges feel that early court involvement with guardian ad litem for the child and an attorney for the parents would help to prevent the development of mental retardation or anti-social behavior. Judge Patrick Tamilia of the Juvenile Court feels that the majority of adult criminals were abused or neglected as children.

Pittsburgh is the home of the just-founded National Center for Juvenile Justice. It is felt this new organization will bring the best legal minds to Pittsburgh and provide an opportunity to reach and educate the local juvenile courts and judges.

The cost of the Pittsburgh Child Abuse program in terms of salaries, amounts to $60,000 annually. Hospitalization for abuse ranges from 3 to 10 days per patient and at the rate of 80 patients per year at $150.00 per day, this adds $36,000 - $120,000 to the total cost of the program.

The SCAN staff of the Children's Hospital would like to increase their outreach and hope to establish a Parental Stress Center in a former adoption home. Here parental shelter treatment would be provided and a crisis nursery established along with physical facilities for teaching and outreach. One big argument for the establishment of a Parental Stress Center is that an abused child could be kept there at less than the cost of hospitalization while the parents' potential to provide adequate care was determined. The grant application providing for the center also includes plans for developing a county wide central registry of high risk families. This will provide 24-hour telephone consultation to hospitals and social agencies for the identification and protection of these children.

Apart from the hospital program, cases of suspected child abuse may be placed in the Child Welfare Services' Shelter. Between 350-400 children suffering from some form of abuse are cared for annually at the Shelter, for an average stay of 48-51 days. Child Welfare has 100 caseworkers for community work.

SUMMARY

The Children's Hospital of Pittsburgh provides a strong child abuse and neglect program for the surrounding community, consisting of active efforts in recognition of cases coming to the center, in- and outpatient medical care, weekly interdisciplinary team meetings, a strong Social Service Department, a Psychiatry Clinic, and good working relationships with the Child Welfare Services of Allegheny County, Juvenile Court, and Neighborhood Legal Aid Services.

Children's Hospital of Pittsburgh

Despite lack of identifiable funding, this is a vigorous program, with coordinated community orientation.

Money is needed to expand the program, and particularly for establishment of the projected Parental Stress Center.

Additional information on file at the Academy office:

1, Questionnaire

2. Site visit reports by individual team members: Dr.Bates, Ms. Elmer, Dr. Lockhart, Ms. Tenne.

3. First annual Neuhauser presidential address of the Society for Pediatric Radiology: on "The Parent-infant traumatic stress syndrome. John Caffey, M. D. Reprinted from the American J. of Roentgenology, VOL CX IV: 2/7, 1972

4. On the theory and practice of shaking infants. John Caffey, M.D. Reprinted from the Am. J. of Dis. of Children, 124: 161, 1972.

THE SCAN PROGRAM

The SCAN (Suspected Child Abuse and Neglect) Program, a term first coined at the Mott Children's Hospital of the University of Michigan, has been operating at Children's Hospital of Pittsburgh for the past number of years. This program has a number of purposes and goals.

(1) to help identify children at risk and see that they get adequate protection and care.
(2) to assist medical house staff in dealing with the problems of abuse and neglect through a 24 hour a day consultation and to establish hospital guide lines for the managment of these children.
(3) To provide continual inservice training programs and community consultation around the multiple problems of child abuse and neglect.
(4) to keep accurate records and constant check and double check on abuse cases.
(5) to arrange for families and children, referred from outside agencies such as Child Welfare and the courts to be seen immediately for medical intervention and/or psychiatric evaluation.
(6) to keep accurate followup on all cases either following these families with other agencies and by giving continual pediatric care.
(7) to hold weekly SCAN meetings with Child Welfare, Medical House Staff, School Officials, members of the law profession and other interested parties in an attempt to build up an informed body of people knowledgeable in the problems of the abused child and his family.
(8) to hopefully do much needed research when indicated and to develop and encourage more innovative community programs in the area of abuse.

The SCAN program is continually implemented by the SCAN committee which is made up of a number of professionals, four pediatricians and five psychiatric social workers who have had long experience in dealing in this area of abuse. The Director of the Committee is Dr. John Reinhart who is both a pediatrician and a child psychiatrist with years of experience and training in this field. A social work coordinator helps to implement the program and to keep communications going between all members of the committee and to "ideally keep all 8 goals of the program functioning. In contrast to other so called abuse teams our committee takes mainly a position of consultation and case review. We will handle cases directly and follow them through with evaluation and assessment only if anxiety on the attending physicians part is too high or if we receive individuals referrals from Juvenile Courts. However, the main emphasis of our program is to get other medical professionals within the hospital to assume responsibility for these cases as a method of their training, and to encourage more active hospital participation in child advocacy.

HOSPITAL PROCEDURES AND MANAGEMENT OF THE ABUSED AND NEGLECTED CHILD

The abused child is a medical and social problem with legal overtones. However, when one gets down to the "nitty gritty" the key to the protection of these children ultimately lies at times within the hands of the physician and the medical facility. No one other than the physician can adequately describe the injuries involved in the meaning of the trauma.

THE SCAN PROGRAM

Without testimony of physician and hospital social worker no physically abused child can be protected adequately from the environment. However, the physician's task is to establish medical facts and not to census, make judgments or punish. The probability of a medical history as related to a set of injuries or neglect is clearly a medical judgment. The determination of the final assessment of the safety or danger to the infants is a legal-social judgment based on evidence not always available to the hospital physician at that particular time. As such, the initial entrance of the child into the pediatric setting in terms of how intervention is made, sets the stage for the eventual outcome of the entire case.

Parents usually bring children to the hospital after the injury has occurred. In fact, bringing the child for care can be viewed as a "cry for help" for a total family in a severe crisis. The non "who done it" approach is our general orientation toward the crisis. Families coming to the hospital are generally fearful they will be seen as bad. They have a life long distrust of authority figures and it is essential for them to develop some kind of at least quasi trust with hospital officials. For the most part parents come from all socio-economic levels even though lower levels are more easily identified at this point. Parents range a broad spectrum of personality types with less than 5% being frankly psychotic. For the most part these are people who have grown up in an atmosphere of conditional love with excessive demands always being made upon them. They are plagued with feelings of worthlessness and powerlessness and have an essential lack of basic trust. They have led a life of chronic depression and chronic losses. Their anxiety is handled by externalizing conflicts; the injury or neglect to the child is a projection of their own self hatred and self depreciation. These parents also were raised in an abusive atmosphere getting very little mothering and nurturing themselves as children. They are isoladed, have no idea or sense of how to use other people or to gain help for themselves. They are generally suspicious and lack support of their spouse. They tend to have unrealistic expectations for and about their children. Generally a severe crisis or series of crises precipitates the incidents of abuse. The crisis can be minimal such as the breakdown of the washing machine or quite severe as the loss of a close relative.

Because the dynamics of abuse are so complicated, special attempts are made not to try to determine who caused the injury but rather make a statement that the child needs treatment and protection and some investigation is needed about how the injury occurred. We are not unwilling to talk with the families about our suspicions of how the accident has occurred but it is important to keep in mind that these are hurt parents of hurt children.

There are certain rules of thumb and criteria that physicians and/or medical people meeting these families for the first time can use to make them more cognizant of if the child has indeed been placed in a high risk situation. These are as follows: If the child has: (1) an unexplained injury (2) shows evidence of dehydration and/or malnutrition without

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obvious causes. (3) has been given inappropriate food, drink or drugs. (4) shows evidence of overall poor care (5) is unusually fearful or docile (6) shows evidence of repeated injury (7) takes over and begins to care for parents' needs (8) is seen as different or bad or evil by parents (9) is indeed different in physical and/or emotional makeup (10) is dressed inappropriately for the degree or type of injury (11) shows evidence of sexual abuse (12) shows evidence of repeated skin injuries (13) shows evidence of repeated fractures(14) shows evidence of characteristic x-ray changes to long bones (15) has injuries that are not mentioned in the history. Also if the parents show: (1) evidence of loss of control or fear of losing control(2) present a contradictory history (3) project cause of the injury to a sibling or another party (4) has delayed unduly in bringing the child for care (5) shows detachment (6) reveals inappropriate awareness or seriousness of the situation (7) continues to complain about irrelevant problems unrelated to the child and/or the situation (8) is personally misusing drugs or alcohol (9) causes antagonism or dislike for some unknown reason by the physician (10) presents a history that does not or cannot explain the injury (11) gives specific "eyewitness" history of abuse (12) gives a history of repeated injuries (13) has no support systems to bail them out with the child (14) is reluctant to give information (15) refuses to consent for further diagnostic studies (16) hospital shops (17) cannot be located (18) is psychotic (19) has been reared in a very motherless non-loving atmosphere (20) has unrealistic expectations for the child. (These criteria are found in Dr Kempe's and Helfer's book, Helping the Battered Child and His Family).

Children under the age of two years are admitted to the hospital always if abuse is suspected whether or not there are injuries. Admission to the hospital is for the purpose of diagnosis and evaluation of the child and the environment in which he lives. Without this, adequate care planning for the child cannot be begun. This is indeed at high financial cost to the hospital but because these children are under the age of two and are most vulnerable, admission is always recommended. In deciding about children over the age of two, the resident physician and/or social worker in the emergency room or outpatient clinic calls one of the SCAN consultants who has experience in dealing with this problem. Decisions are then made in regard to the management of the particular case including whether or not admission is indicated and trying to determine the key question--is it safe for the child to go home? In those cases where it is felt that the child should be placed outside his home but whereas not felt necessary to admit this child to the hospital, children are admitted to a nearby Child Welfare Shelter on a 24 hour basis.

Because in many instances parents are unwilling for investigation of their caretaking abilities or for the hospitalization of the child, a restraining order can be obtained on a moments notice from a juvenile court judge which keeps the child in protective custody until such investigation of the problems of the home can be determined.

Most children coming to the hospital abused are admitted. At such time a whole system of immediate intervention takes place. There is a

THE SCAN PROGRAM

psychiatric social worker assigned to each medical unit who immediately along with the attending intern or resident interviews the family regarding the injury and/or crisis pending the child and family coming to the hospital. A member of the SCAN committee is consulted; the case is staffed, hopefully within 24 hours, and a decision is made as to whether a verbal and later written report should be made to Child Welfare. At this point, a statement of the SCAN consultation is written and the patient's chart and disposition and reasons for the disposition of this particular case. This is done so that a senior staff person can be an expert backup especially if the case comes to court. It is also important because anxiety around this kind of decision making is high and reporting is therefore a "shared" responsibility.

An immediate physical history and workup is crucial to the life saving recognition of these children. The diagnosis is not always clear cut and is unpleasant for staff members. However, a consistent approach of these children we have found to be most helpful. Histories of the accident must include the usual where, how, when, who. Detailed family and social histories are often useful however cannot always be obtained on the spur but are usually obtained by the psychiatric social worker assigned to the case over a period of days. These records are kept separate from the medical chart. Physical exams are done in detail and recorded with more than usual care. Special attention is always given to height, weight and growth curves. All abnormal findings are recorded as well as significant negative statements. Laboratory work is ordered on an individual basis however at times if the parent says the child bruises easy it is important to get some studies of clotting mechanisms. Perhaps most important is the diagnostic approach of skeletal survey to determine that there are old or resolving fractures. This is frequently a key issue in terms of whether the child has been exposed to trauma before. Denver developmental profile should be done on the child as well as colored photographs when indicated. Nursing notes have proved invaluable in terms of parent-child interaction, parental visits and descriptive characterizations of the child.

Once the immediate medical crisis has been cared for with the child all attention must then shift from the child to the parents. They are then given intensive support in the relationship with the social worker and the attending physician. Parents are helped to get to the Child Welfare system as expediently as possible and they are always referred to legal counsel. In cases of those admitted where the child does not return to the home continued contacts are kept with the parents offering them support until they can get to the appropriatehelp and agency and some disposition has been

made regarding the child. We make continued use of Public Health Nursing, Homemaker Services, Community Mental Health, Day Care and early infant stimulation programs throughout the city.

The key to optimal crisis intervention of these families rests with continued collaboration with other professionals outside the hospital setting. This means intensive collaboration with local child welfare agencies and giving them as much support and information as possible for them to make an adequate decision. Physicians and other medical people provide testimony in written form and also appear in court; this means giving them time off from their medical duties to testify in court, a hospital policy that has always been recognized and encouraged.

Traditionally the Child Welfare system has been the scapegoat of people's wrath and confusion about abuse. They are overworked, underpaid, under-staff agency trying valiantly to meet the needs of the many small helpless victims that we get to refer to them for care. They have not received the kind of medical support that they so desperately need from the hospital and all efforts on our part is to try to give this to them in the best interest of the child. If a child goes home or is retained in the foster home or shelter, continuing medical care, social casework or psychiatric evaluation is offered to the families and the agencies for indefinite period of time. If we at any point disagree with Child Welfare's assessment of the situation the hospital itself can petition the court in behalf of the child or petition the court to obtain legal counsel for the child.

As has been mentioned, all cases involving suspected child abuse and neglect are immediately referred to our Social Service Department. Weekly reports and status of cases also are given to hospital administration and the medical director. We keep all records of all reported abuse cases and accidents that are found in our hospital or regional pediatric hospitals. Medical records also stamps the charts of all patients with a large red "SCAN" that is an identifying mark and alert system for these children should they appear in our Emergency Room and/or Medical Clinic at another time. Emergency visits are also screened everyday for potential SCAN cases that might have been "missed".

Followup studies done in our hospital and elsewhere indicate that usual attempts of general supportive help to families while the child is hospitalized or after on an outpatient basis or foster care placemtne does not attack or alleviate the problem in any substantial way. Abuse and neglect is a medical, social, and legal problem and as such highlights the lacks of continuity of care between these three very important aspects. We feel that as

a medical facility we cannot deal at all with this problem in our own isolated way. Child Welfare and Juvenile Court systems have always been involved; and now, with the 1967 Supreme Court decision on the manner of Galt which made legal representations to minors and juvenile delinquency cases a constitutional right, the legal thrust and growth in the area of child advocacy and particularly in abuse and neglect has boomed. School systems and other caretaking child facilities have also become increasingly interested in this problem. We therefore have established at Children's Hospital weekly SCAN meetings to which come members of the medical profession, Child Welfare experts, lawyers, police, and school personnel. At such meetings abuse and neglect cases are discussed and reviewed and each discipline is able to share and communicate with each other their views on the problems and ways the case could be handled most efficiently and effectively. These have been exciting meetings out of which have come tremendous enthusiasm and community support for looking at the abuse and neglect problem within our city as a whole.

From these meetings we hope to develop many innovative kinds of programs some of which have been used successfully in other citites. We function chiefly now as a review of cases and implementation of child advocacy is our first prerogative. We hope eventually to be able to establish parental hotlines, parents anonymous, lay therapists, crisis nursery's, etc. We have expanded our interests of collaboration towards the juvenile court judges and are currently exploring the possibility of an experimental project to take care of the most serious cases of abuse, which children must be separated from their families for a long period of time to adequately diagnose their parents caretaking abilities. Such observation and information is absolutely necessary when it comes to advising the court in hearings concerning custody and eventually if it is determined whether parental rights must be terminated.

At times the burdens, headaches, and anguish of the multiproblems with these families and children become overwhelming. Progress seems to move at a snails pace; however, if one keeps in mind that the mandatory reporting law has only been in effect since 1967, there have been significant gains in this area. Our philosophy has been, that unless our society can provide adequate prevention and interventive techniques, hundreds and thousands of children will not have the chance to grow into healthy adequate adults and instead will be burdened with the legacy of retardation, inadequacy, dependency, and loneliness and will become parents of still another generation of abused and neglected children.

CHILDREN'S HOSPITAL OF PITTSBURGH
Pittsburgh, Pa.

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John S. Reinhart, M.D.
Dept. of Psychiatry, Dir. CA/N

Date & basis for establishment of CA 'N program	1965
Location	Hospital
AUSPICES: Hospital, Medical School, Health Dept., other (explain)	Hospital
Medical School affiliation	Yes
FUNDING: Grant (type), public, private, state institution, other Allotments if any for CA 'N Funding restraints Copy of budget attained	See text
PATIENT STATISTICS # inpatients year # outpatients year # abused patients admitted year # abused patients treated in outpt dept year # sexually abused year # neglected year	9,500 100,000 + 90 15 80 598
CA 'N TEAM Composition & % of time in CA 'N Head — Pediatrician — 25 Coordinator — M.S.W. — 80 Hospital Administrator — 0 Pediatrician — from PCC — 5 to 10% Physician — Psychologist — 50 to 60 Surgeon — No Nurse — No Social Worker — Two — 50 Attorney — No Other (state) — -
Does Team see all suspected cases of abuse? neglect?	Yes Yes
Are there written, procedural guidelines for Team? Who developed them?	Yes Team
PATIENT FLOW Seen — % through Emergency Room % through Pediatric Clinics & Wards % through Child Welfare Social Service % through neighbor report % through private physician % through parental call for help % through police % through school % Other (state)	75 - 10 ≤10 ≤ 1 ≤ 1 5 5 -
INFORMATION COLLECTED ON PATIENTS Full medical, social, psychological history? Family profile? (information on sibs and parents)	Yes Yes
DIAGNOSIS - IDENTIFICATION By CA 'N team according to established criteria By individual physician or ER staff Previously identified and sent to center for confirmation and treatment	Yes
TREATMENT 24 hr medical, surgical treatment available Psychological service	Yes Yes
EVALUATION of child For emotional disabilities For learning disabilities For physical disabilities Evaluation of PARENTS? Evaluation of SIBLINGS?	Yes Yes Yes Yes Yes
REHABILITATION Medical, surgical Psychological Short term rehabilitation Long term rehabilitation Referral to other treatment center If return appointments are not kept, is there follow up and by whom?	Yes Yes Yes Yes Yes Aide
COST OF PATIENT CARE Estimated for Treatment, Evaluation, Rehabilitation	$150/day
FOLLOW UP Is there feedback to program from Protective Services?	Yes
CASE CONFERENCES - in facility Held regularly, weekly or monthly All members of team attend Conference on special call Professionals from community attend?	Weekly Yes Yes Yes

COMMUNITY CHARACTERISTICS Boundaries for population surrounding health facility Economic class Ethnic composition	See text
POPULATION SERVED BY PROGRAM All from surrounding community Economic status Ethnic composition Patient population not selected by center Special category	See text
COMMUNITY RESOURCES Day Care Center 24 Hours Crisis Nursery Foster Home Therapeutic foster home Hotline Parent Aides Parents Anonymous or other self-help group Homemaker Other, ex. Public Health Nurse If available, would you use all or most of these?	No No Yes Yes No No No Yes Yes
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE? Does it relate with hospital team?	No
EDUCATION In Community - lay public In Hospital School of Medicine and Nursing Public schools Police Department Other (state) Pharmacy, PHN, Courts, TV	PTA SCAN Lecture Yes Yes Yes
PROTECTIVE SERVICES Hospital and Community cooperate Can child be held without parents' consent?	Yes Court order
CRITERIA for considering home "safe" developed with hospital participation	Yes
REPORTING mandated? Abuse reports - by Team or individual? Report sent to: Investigated by: Neglect reports - by Team or individual? Report sent to: Investigated by: Reporting procedure weekends, holidays, 24 hours? Parents informed of reporting?	Yes Team Welfare Same No Yes
REGISTRY - in hospital Central registry in state or community Is central registry effective? Can it be used by CA 'N team? Can complainant be expunged from record?	Yes No
DISPOSITION Joint decision by team and protective service Conference with family before disposition hearing % returned home % returned home under protective custody % removed to Foster Care % termination of parental rights Any team members involved in court hearings?	- Yes Un-known Testify
GUIDELINES AND CRITERIA for Abuse - written? unwritten, flexible on individual basis for Neglect - written? unwritten, flexible on individual basis Established criteria for considering home "safe"	Written, developed by Team Yes
PROFILE OF ABUSER Alcohol a factor in abuse Drugs a factor in abuse	Parents, sitters, sibs Not known
MCH CASE FINDING - PREVENTIVE EFFORTS Search of admission charts and x-rays? Surveillance of newborns in abusive family? Observations by obstetrical nurses? Identification of "high risk" mothers in prenatal clinics?	Yes Yes Yes Yes
FAMILY COUNSELING? Family planning recommended?	Yes Yes
RESEARCH - ongoing New study or expansion of research planned	Yes Yes

SITE VISIT NO. 9

St. Paul-Ramsey County Mental Health Center
St. Paul Minnesota
January 8, 1974

Ramsey County, in east central Minnesota, contains St. Paul, population 400,000, and a score of tiny, peripheral communities. Residential and commerical - the city is surrounded by farmland. The population is relatively stable, white Protestant -- under 2% black -- theabusers urban poor.

St. Paul has two major hospitals for children: St. Paul-Ramsey County General Hospital and St. Paul Children's Hospital. A number of smaller hospitals also treat children. One of these apparently does not report abuse. Different opinions exist as to the level of child abuse reporting; but the level is high, one observer estimating 95% of abuse is reported.

In 1969, Ramsey County officials, at the urging of the Judge of Juvenile Court, undertook to develop a program which would coordinate the work of local medical, legal and social agencies. This plan was backed by the Chief of Pediatrics at St. Paul-Ramsey Hospital, Homer D. Venter, M.D.; the Chief of Psychiatry at the Hospital, Vincent B. Tuason, M.D.; and the Program Director at the Community Mental Health Center, John M. Catlin.

The Ramsey County Child Abuse Team was established after a visit to Denver, Colorado, whither a group of eleven St. Paul Community leaders had gone to see what they could do about their community needs. The team is headquartered in, and its coordinator employed by, the Ramsey County Mental Health Center with County and State Department of Public Welfare funding.

This is a community-wide team, which meets weekly and on call at the Mental Health Center. All team members -- two pediatricians representing the major children's hospitals, psychiatrist, psychologist, three social workers, a police officer and a P.H.N., plus those persons involved with the case --see or staff new cases. The more severe or difficult cases, usually referred by a "mini-team", are seen. The "mini-team" --coordinator, police investigator and Family and Children's Services supervisor -- meets weekly, often in the hospital with local staff, discusses all cases of suspected abuse, and makes a disposition plan which may include referral to the Child Abuse Team. Staffing and procedures are flexible. There is also a "treatment team" which consists of the case worker and whoever else is treating the child and family.

The team holds a retreat every six months to review its progress and modify procedures as indicated.

The community plan is a long-range, integrated plan with inclusion of other disciplines at various developmental stages, e.g., clergy and lay leaders will be added at a later expansion stage. The program is not called a mental health program, welfare program, police program, etc., but a community program. Action can begin within a few hours of a phone call.

A disposition plan may be: direct referral to Child Protective Services or other Welfare Department services, or referral to the Child Abuse Team. Decisions are team decisions. The worker accepting the case brings it back for review whenever she wishes to, or whenever the team asks her to. The "treatment team", which usually forms after disposition, also meets regularly and by agreement. An individual worker may present a case for review every few weeks, need remain only for her own case to be presented, and is stated to consider the time spent in team conference valuable in education and decision making.

Perhaps because of the total community involvement, including that of the police, about 45% cases of reported abuse are not initially admitted to the hospital. Parental cooperation is the general rule, and court appearances the exception. Minnesota law requires dual reporting to both police and social services, a requirement apparently conformed with only in Ramsey County.

Cases are followed essentially indefinitely. Social workers and public health nurses share the majority of the several times a week home visits which are usually made. Supportive services such as psychiatry are adequate, though some community services, notably for crisis and overnight care, are lacking. Social workers and attorneys go to neighboring counties to appear in court or at case conferences when they feel this is in the interest of a child whose parents have moved.

Referring physicians from other than St. Paul-Ramsey County and Children's Hospital are included in all aspects of case disposition and are provided detailed information on case progress. Specific liaison relationships also exist with staff from some of the smaller hospitals. These relationships are part of the Team's education and outreach program.

Intake is broad: 21% through the Welfare Department; 9% through private physicians; 8% through nurse reporting; emergency rooms -- 35%; wards and clinics -- 12 %; police -- 10%; and schools -- 4%. The intake category "parental call for help" is included in the 35% who enter through the emergency room. In the major and cooperating hospitals, all suspect cases of abuse are admitted. About 25% of all cases require admission for treatment of injuries sustained in the abuse incident. The remaining admissions are for establishment of diagnosis and treatment plan.

The Child Abuse Team management protocol is attached.

The team is headed by Shirley Pierce, Coordinator, and consists of a psychiatrist, a clinical psychologist, three social workers, two pediatricians, a police investigator, and a public health nurse. Dr. Venters, Chief of Pediatrics at St. Paul-Ramsey Hospital and a team member, teaches interns and residents, stressing the dynamics of injury. He believes it is necessary for pediatricians to expand their vision and treat the whole child; look for neglect, and other social factors as well as disease entities. He teaches a course in Maternal and Child Health at the University, a course which has an enrollment of 42 students.

There is a keen awareness of psychological indications for admissions when a child is brought in to be seen. A child crying for 12 hours with an upset mother, for example, might well be admitted. A study conducted by Dr. Venters and Dr. John F. Perry (Childhood Deaths Due to Injury, Surgery 62: 620-623, October 1967) covers 99 children who died violent deaths during a five year period. There were 67 males, 32 females; 12% of the children were under a year of age; 36% less than 3. There were 12 homicides; of these, autopsy studies indicate 7 were most likely "battered children."

Demographic data have been studied. About 90% of parents were themselves deprived, neglected, or abused. The children are observed to be retarded in all areas. An observation being tested currently is that children do better in foster homes than in their own families even when under court supervision.

A Day Care Center is available, but not on a 24-hour basis, nor is there a Crisis nursery. St. Paul has no Parents Anonymous and no hotline. When a child is temporarily placed away from home, the usual procedures would include: 1) weekly visits by a child protection social worker, and 2) weekly or bi-weekly visits by a visiting nurse if there were pre-school children in the home, and 3) therapy for the parents. The schools provide surveillance if the children are of school age.

The length of foster home placement varies considerably depending on the reason for removal and the parents' response to therapy intervention.

One of the community resources is Wilder Center. This is a private center in the greater St. Paul area serving children with severe emotional problems. It also acts as a residential facility for these children. Dr. Knowles, a psychiatrist, is director of the Intake Department at the County Hospital and also at Wilder. At the time of the site visit, Wilder had 12 cases of children brought in through the CA/N team. At Wilder, referrals are received from the CA/N team, court, Welfare Department, some walk-ins, and other referrals of wealthy patients from private pediatricians. Seventy foster homes are available to Wilder Center.

At the Children's Hospital in St. Paul, every patient can be used for teaching unless otherwise stated at the time of admission. Children's Hospital is a private hospital; the Pediatrician-in-Charge, Caroline Levitt, M.D., is a member of the Mental Health Center ream. Management of child abuse, especially in the emergency room, is taught to the house staff. The house staff reports child abuse; many times a private physician will send a child to the hospital to be reported. Parents are informed when it is necessary to report suspected child abuse and told that a worker will come to their home. Social workers at Children's Hospital try to follow the abused children until they reach school age.

SUMMARY

This is a broad-based, comprehensive community approach to the problem of child abuse and neglect. Since establishment in 1969, it has continued to expand. It has a built-in system for involvement of more disciplines yearly. There appears to be a good relationship between the member agencies.

With the exception of one area hospital, there is close to complete case finding, reporting, and long-term follow-up in the area served. The team is community-wide, meets in a mental health center, makes good use of its police, social worker and nurse members, and sees cases at intervals as desired by the protective service worker or the team's decision. There is no doubt that the Child Abuse Team coordinator aggressively keeps the team and the community together.

The team concept here serves a city this size well, but might not be suitable for a larger city.

Additional information on file at the Academy office:

1. Questionnaire.

2. Site visit reports by individual team members: Dr. Bates, Ms. Pambrun, Ms. Tenne.

3. Childhood deaths due to injury. Perry, J.F., Venter, H.D. Reprint from Surgery, 62: 620, 1967.

4. Report of characteristics accumulated from 53 confirmed child abuse cases referred for social service in 1972, Ramsey Co. Unpublished.

5. Annual report, Child Abuse in Minnesota, 1972. State of Minnesota.

6. Preliminary research by Winifred Scott, clinical psychologist, on a subsample of 81 families in which one or more children were physically abused or severely neglected. Unpublished.

7. Police recruit training in child abuse. Sgt. C. Bailey, St. Paul Police Dept. Unpublished.

III. WHAT DO DO NEXT?

A. Hospital Procedures -- When preliminary identification of child abuse has been made or is suspected, the following procedures are to be followed.

1. The private physician must be consulted regarding your concern and intention to report your suspicions of child abuse. He/she may be extremely helpful in working with the parents and may offer valuable background information to the report. He/she may need to know the protocol for reporting and the current law.

2. The child is generally hospitalized temporarily for his protection and to allow time for documentation of the injury by x-ray and laboratory tests. A very careful history should be documented in exact words of the parent or informant. This history is extremely important in situations where there are conflicting histories reported later by the same or another informant.

3. A very thorough physical examination is then completed documenting any old or new scars and bruises by additional history.

4. Specialty consultants in Orthopedics, Urology, Neurosurgery, Radiology and General Surgery (burns) may prove to be extremely valuable in documentation of the specific injury.

5. Contact with the parents by hospital personnel should, in no way, denote rejection, hostility, or judgmental attitudes. These attitudes do nothing but antagonize the parents and make future communication most difficult. Parents are usually cooperative if, when help is offered, it is not accompanied by threats and accusations.

6. An interview with parents, reporting physician, Dr. Carolyn Levitt, attending physician, and social worker or coordinator of the Child Abuse Team is to be scheduled after completion of medical findings.

7. A temporary disposition plan is made by hospital staff concerning discharge planning. This plan is coordinated with investigation of police and contact by welfare department.

8. If the case will be scheduled by the Ramsey County Child Abuse Team, Dr. Carolyn Levitt or Shirley Pierce will contact concerned hospital staff regarding staffing time.

9. The Department of Pediatrics is also concerned about those children whose parents are threatening to injure children. Hospital admissions for protective purposes are viewed as life-saving medical concerns.

IV. HOW TO REPORT SUSPICION OF CHILD ABUSE.

1. Report addressed to: (written)

   a) Mr. Wayne Fox
      Child Protection
      Ramsey County Welfare Department

   b) Mrs. Carolyn Bailey
      St. Paul Police Department

   c) Copy to Mrs Shirley Pierce
      Child Abuse Coordinator
      Ramsey County Mental Health

2. Report should include the following:

   a) Identifying information

   b) Description of injury
      - comment on severity
      - medical condition of child

   c) History given
      - are there conflicting stories?
      - does explanation fit with injury?
      - likelihood of trauma

V. CHILD ABUSE TEAM OF RAMSEY COUNTY

Responsibility for reporting

Minnesota, in 1963, was one of the first states in the nation to pass a law to safeguard the physically battered child. The law required that all physicians and medical personnel report suspected child abuse to the police and the county welfare department.

The law as amended in 1965 spells out the responsibility of the County Welfare Department in protecting a child from further abuse, provides immunity from legal liability when reporting a case of a battered child, excludes physician-patient and husband-wife privileges in any judicial proceedings resulting from a report of an injured child, and makes it a misdemeanor for failure by medical personnel to report suspected child battering.

Philosophy of Community Team

There exists, in Ramsey County, an established cooperative effort to deal with the physically battered child. This effort has taken the form of the Battered Child Team, a group composed of representatives of: The Departments of Pediatrics, Social Work at St. Paul-Ramsey Hospital, the Community Mental Health Center, Ramsey County Juvenile Court, the St. Paul Police Department, the Ramsey County Welfare

Department, and the Ramsey County Nursing Service, and Children's Placement Service. The philosophy of this Team is that child abuse is predominantly a mental health problem affecting not only the individual child, but also family and community stability, and that treatment of the parents and children should therefore transcend a provincial professional view and represent a multi-disciplinary, comprehensive concept of intervention so to insure a well-coordinated, long-range and effective resolution of the problem.

Scope of Work

Investigation, evaluation, disposition and treatment are four dimensions of diagnosing of this medical, legal and social problem. Since each of these phases requires different skills and each discipline is working within its area of responsibility concurrently, coordination is a crucial factor. Each phase of examination is closely related and dependent upon the other -- superimposed on this assessment process is the element of time. Immediate gathering of information from the investigation and evaluation processes is essential. The purpose of the Team is to rapidly implement the different processes to work effectively in order to arrive upon a disposition concerning the safety of the child, which may or may not require the request for the protection of Juvenile Court. The treatment responsibilities are assumed by treatment agencies on the Team.

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RAMSEY COUNTY CHILD ABUSE TEAM

Saint Paul-Ramsey County Mental Health Center

Shirley Pierce, Coordinator

Date & basis for establishment of CA/N program:	8/69
Location	MHC
AUSPICES: Hospital, Medical School, Health Dept., other (explain)	MHC
Medical School affiliation	Yes
FUNDING: Grant (type), public, private, state institution, other	State & County
Allotments if any for CA/N	Dept. Pub-
Funding restraints	Welfare
Copy of budget attached	-
PATIENT STATISTICS	
# inpatients/year	Not
# outpatients/year	avail-
# abused patients admitted/year	able
# abused patients treated in outpt dept/year	250
# sexually abused/year	-
# neglected/year	14
	2,000
CA/N TEAM	
Composition & % of time in CA/N	
Head M.S.W.	100
Coordinator "	"
Hospital Administrator	3
Pediatrician Two	Per-
Physician Psychiatrist-Psycholog.	centage
Surgeon	n.a.
Nurse	0
Social Worker	(3) ?
Attorney	No
Other (state) Nurse, Police Dept. Sgt.	
Does Team see all suspected cases of abuse?	Yes
" " " " neglect?	No
Are there written, procedural guidelines for Team?	Yes
Who developed them? MHC &	Team
PATIENT FLOW	
Intake - % through Emergency Room	24
% through Pediatric Clinics & Wards	4
% through Child Welfare/Social Service	24
% through neighbor report	4
% through private physician	6
% through parental call for help	4
% through police	24
% through school	10
% Other (state)	2
INFORMATION COLLECTED ON PATIENTS	
Full medical, social, psychological history?	Yes
Family profile? (information on sibs and parents)	Yes
DIAGNOSIS - IDENTIFICATION	
By CA/N team according to established criteria	Yes
By individual physician or ER staff	
Previously identified and sent to center for confirmation and treatment	
TREATMENT	
24 hr medical-surgical treatment available	Yes
Psychological service	Yes
EVALUATION of child	
for emotional disabilities	Yes
for learning disabilities	Yes
for physical disabilities	Yes
Evaluation of PARENTS?	Yes
Evaluation of SIBLINGS?	Yes
REHABILITATION	
Medical-Surgical	Yes
Psychological	Yes
Short term rehabilitation	Yes
Long term rehabilitation	Yes
Referral to other treatment center	Yes
If return appointments are not kept, is there follow-up and by whom?	S.W. con-
	tacts
COST OF PATIENT CARE	
Delineated for Treatment, Evaluation, Rehabilitation	$132/day
FOLLOW-UP	
Is there feedback to program from Protective Services?	Yes
CASE CONFERENCES - in facility	
Held regularly, weekly or monthly	Weekly
All members of team attend	Yes
Conference on special call	Yes
Professionals from community attend?	Yes

COMMUNITY CHARACTERISTICS	
Boundaries for population surrounding health facility	See
Economic class	text
Ethnic composition	
POPULATION SERVED BY PROGRAM	
All from surrounding community	See
Economic status	text
Ethnic composition	
Patient population not selected by center	
Special category	
COMMUNITY RESOURCES	
Day Care Center/~~24 Hours~~	Day only
Crisis Nursery	No
Foster Home	Yes
Therapeutic foster home	No
Hotline	No
Parent Aides	No
Parents Anonymous or other self-help group	Yes
Homemaker	Yes
Other, as Public Health Nurse	Yes
If available, would you use all or most of these?	
COMMUNITY CHILD ABUSE COUNCIL OR COMMITTEE?	
Does it relate with hospital team?	Team fills need
EDUCATION	
in Community - lay public thru media	Yes
in Hospital	Yes
School of Medicine, Law, Nursing	Lectures
Public schools	Yes
Police Department	Yes
Other (state)	Court
PROTECTIVE SERVICES	
Hospital and Community cooperate	Yes
Can child be held without parents' consent?	If necessary
CRITERIA for considering home "safe" developed with hospital participation	-
REPORTING mandated?	Yes
Abuse reports - by Team or individual? Team dec.	Coord.
Report sent to:	Police &
Investigated by:	S.S.
Neglect reports - by Team or individual?	Same
Report sent to:	
Investigated by:	
Reporting procedure weekends, holidays, 24 hours?	Yes
Parents informed of reporting?	Yes
REGISTRY - in hospital	No
Central registry in state or community	No
Is central registry effective?	
Can it be used by CA/N team?	
Can complaint be expunged from record?	-
DISPOSITION	
Joint decision by team and protective service	Yes
Conference with family before disposition hearing	Yes
% returned home	36
% returned home under protective custody	26
% referred to Foster Care	28
% termination of parental rights	16
Any team members involved in court hearings?	
GUIDELINES AND CRITERIA	
for Abuse - written? unwritten, flexible on individual basis	Written
for Neglect - written? unwritten, flexible on individual basis	Written
Established criteria for considering home "safe"	Yes
PROFILE OF ABUSER Mother, father, b.f., step.	
Alcohol a factor in abuse	1/4
Drugs a factor in abuse	1/4
NEW CASE FINDING - PREVENTIVE EFFORTS	
Search of admission charts and x-rays?	See
Surveillance of newborns in abusive family?	text
Observations by obstetrical nurses?	
Identification of "high risk" mothers in prenatal clinics?	
FAMILY COUNSELING?	Yes
Family planning recommended?	Yes
RESEARCH - ongoing	Yes
New study or expansion of research planned	Yes

IV. SIMILARITIES AND DIFFERENCES

The nine programs chosen represent variety within the framework of a health base and a multidisciplinary approach. Each is unique; yet they have many commonalities. This section of the report presents some of the highlights of their similarities and their special attributes.

All have relationships to hospitals. However, hospitals range from the children's service of a large, busy, county general hospital to several children's hospitals, to community hospitals, to a foundling hospital which is one element of a large social agency. The latter program receives child abuse patients, as mother and child, only on referral for treatment after the diagnosis had already been established. In this regard it is different from all of the other sites that were visited. It does not have to deal with the initial recognition and initial management of abuse or neglect. Moreover, its treatment regime is residential for mother and child. Many facets of the planned inquiry were not relevant to its operation.

Relationships to medical schools or teaching hospitals, or both, are the rule. Here, too, there is a range in intensity. In Denver, the chairman of the Department of Pediatrics of the medical school is the director of the program; in New York, residents from a nearby teaching hospital make rounds with the director and cover the service.

The key staff at the nine sites visited include many of the pioneers who have done some of the basic writing which has brought child abuse and neglect into prominence. However, there is also a new generation represented. It is comprised of physicians, primarily pediatricians, nurses, psychologists, social workers, lawyers, and also liberal arts graduates and police officers. It is noteworthy that they all display dedication, warmth, enthusiasm, leadership and acceptance. It is difficult to see how the programs could function if the directors and coordinators lacked any of these qualities.

The multidisciplinary approach is manifest in the Child Abuse Team. Consistently it includes a pediatrician and a social worker. Most of the time there is a psychiatrist or a psychologist, often both. Other disciplines represented less often are nursing, hospital administration, law, police, and even a surgeon. All teams have coordinators designated, usually someone with training in one of the above disciplines. In many instances, the official child protective services worker is an integral part of the team and invariably meets with it.

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Teams meet regularly, varying from monthly to twice weekly. In addition, they all have ad hoc meetings when circumstances require. Although these meetings -- and most of the team's joint activities -- take place in the regular quarters of the program, two programs sent pairs or trios of their members into community hospitals or agencies for meetings and case conferences. In Hawaii, this is done on contract with local community hospitals. In Minnesota, it is part of the complete coverage of the county. Team decisions are said to be arrived at by consensus; in many instances the Protective Services agency reserves the right to take independent action.

Minutes of team meetings are kept, but vary in quality. The center with the most elaborate minutes maintains a list of all active cases, resumes of cases whose status had changed since the previous meeting, details of cases previously reviewed and resumes of the cases to be discussed at the present meeting. This center (Army) specifically lists a clerk in its personnel roster.

All of the programs have medical and surgical care. If these services are not actually based in the hospital, they are readily accessible and the relationship is good. Long-term care for physical rehabilitation is also easily obtained. A few programs provide long-term rehabilitation for the family's psychosocial pathology; in others, it does not even exist.

Feedback is a problem. For instance, the Cook County team is obliged to refer all cases to Protective Services for follow-up and disposition; rarely is the hospital informed of the outcome of a particular case. In Iowa, referrals are made to a practically non-existent county service. Other programs can keep under treatment only a fraction of the cases they encounter. Eight of nine programs feel the need for greater communication in this area.

Intake is preponderantly through the emergency room when the program is based in a hospital that runs an active emergency service. In these cases the police often are the first agency called and bring the child for care as the first priority, irrespective of whether they are involved with the team in subsequent management. The pattern of intake sources is extremely variable. Where there is a program with strong community ties and a vigorous community education effort, other sources such as schools, neighbors, and abusing parents themselves account for substantial percentages of referrals. Only in Denver are the parents separately categorized as "parents' call for help"; elsewhere, if it is recognized, it is simply included with the emergency room compilation. Referrals by private physicians for suspected abuse or neglect are non-existent or minimal at all sites. The reported ratios of suspected or confirmed cases to outpatient or inpatient volume of the back-up hospital are meaningless because of differences in definitions, incompleteness of reporting, insensitivity and unawareness.

Similarly, percentages of abused, neglected and sexually abused have no validity. Only three places of the eight that would have received them even count separately the number of sexually abused children. Alcoholism is reported to be a contributory factor in abuse or neglect by five centers. Other drug dependency was only mentioned by two.

Case management depends upon the age of the child and on the severity of the problem. New cases of suspected physical abuse in infants are invariably admitted to the hospital for at least 24 hours for diagnosis and therapeutic planning. Older or previously known cases are admitted if there are injuries that need treatment or it is thought that the child is in urgent need of protection. However, management varies from program to program depending on the facilities and services available, the degree of cooperation with protective service capabilities and the accessibility of the site.

Holding the child in the hospital is seldom thought to be a problem, except at times in Chicago. The non-judgmental "let's bring your child into the hospital for some studies and see what's happening" usually permits admission without the need for police or protective services hold. In Denver and Minnesota, where the programs are best known to the public, voluntary cooperation from parents is greatest. "Arrests" of the child, protective hold and/or court proceedings are always reserved for cases where there is lack of cooperation; they can be invoked readily.

Written guidelines for diagnosis and procedure in both abuse and neglect are in use in seven of the sites, and under development in the other two. No one ever claims sole authorship; they seem to emerge from common team considerations.

Except at Cook County, decisions about disposition are made jointly by the child abuse team and protective services, but as noted above, at half of the sites the protective services worker does not always follow the team decisions. There is a cooperative follow-up effort between the team and the protective services agency in seven of the programs. This does not occur in Iowa in part because of a legal opinion from the University attorney that the program should not reach out beyond the institution. In Chicago, there seems to be a lack of genuine collaboration between the protective services agency and the 63 hospitals it has to deal with.

Families of abused and neglected children are generally informed of what goes on. The informed parental role begins in the intake procedure and includes being informed of reporting. In some programs, parents actively participate in decisions. In Ramsey County, the treatment agency makes written, signed contracts with the parents outlining the treatment plan and getting parental agreement.

The foster home is the basic modality for removal of the child from his natural home, short of, or after hospitalization. Yet there is generalized dissatisfaction with the run-of-the-mill foster homes. Five of the programs are developing therapeutic foster homes. The amount of treatment and supervision once out of hospital, regardless of foster home placement, ranges from virtually nil to several calls a week for an indefinite period. It is a direct reflection of the magnitude of the resources and intensity of the commitment of the protective services agency in relation to the case load. The duration of foster care is known to the team only when it is cooperatively involved in the follow-up, and not always then, although efforts are being made to improve this aspect of communication.

Some degree of contact with parents whose children are returned home is maintained for emergency situations by all programs. A "hot line" or the equivalent of someone available to talk to exists in most programs. Emergency and social hospital admission, and sometimes extended hospitalization, are practiced in every program. Parents already in the program who become concerned about their behavior towards their children can leave them until the crisis has passed.

Day care or nursery care on a crisis basis are available at only one location each. In general, the only way to separate a child from its anxious, distraught parent is through the hospital admission route. In New York, the protective services agency is making available temporary, emergency foster care and emergency homemakers are being developed; but this is completely independent of the Foundling program. Lay workers, parent aides, homemakers on a scheduled-in-advance basis exist in varying degrees in all of the programs; parent groups are found in some. (Iowa is a notable exception)

Prompt follow-up and investigation of the entire family is practiced, or is just beginning to be practiced, at each program. Generally, the siblings of the index child are examined and attention paid to their progress during the family-treatment phase. Other case-finding activites are undertaken. An experienced social worker reviews the Emergency Room records at one site. Three programs scan all cases where x-rays show fractures in young children. The yield from these procedures could not be ascertained.

Nurses played an important role in half of the programs. They are team members and general participants in the preparation of cases and decisions on disposition. It was remarked that they could go into homes where no one else would be accepted. In Ramsey County, where police have an important investigatory role, the nurses are particularly involved when police are denied entry. The programs with aggressive case treatment, intensive follow-up, and attempts at prevention all include nurses in the therapeutic team. The nurses share calls with the protective services social workers. It appears that the health base of these programs facilitates the utilization of nurses.

Lawyers are full-fledged members of the child abuse treatment team at two centers. They are available as consultants at most of the other sites. Only two indicated no relationship with the legal profession. The lawyer's role varies. When a case goes to court, generally he prepares the other team members for court testimony and aids in translation of the diagnosis and treatment plan into proper legal form so that there can be a favorable court decision. Even without court appearance, the lawyer's participation in the team decisions is said to assist in its decision-making.

All of the programs located in hospitals have their own registries. These appear to be restricted to confirmed or suspected cases that had presented at the institutions. They were available to Emergency Room staff, and they seemed to be useful. The Army recognizes the value of a medical record that accompanies the families when they move.

Central registries are maintained in five of the states; only in Hawaii was the central registry considered to be effective and useful. In general, communities and states lacking registries would like to have them; but those who have them are dissatisfied. Among the complaints were: available only to protective service personnel, only confirmed cases listed, not accessible nights and weekends, insufficient information recordded, and difficulty in correcting data.

Serious, long-term followup of the multidisciplinary approach, and an attempt to make control observations, are really just beginning in child abuse. All of the programs are either doing, or plan to do, research. Longitudinal observations of physical and cognitive development of children under treatment after having been abused are under way in Denver and planned in Los Angeles and Hawaii. There is inter-program collaboration between the latter two and the group at Boston Children's Medical Center. In general, where there is collaborative followup with the protective services agency, there is documentation of a reduction in the number of deaths of children who had previously been abused, even though they remained in their own families. The incidence of repeated abuse once brought under treatment is said to be about 5% in several centers. Programs have not been operating long enough to assess changes in family dynamics. However, the Denver group indicates that a change in lifestyle has been observed in about 25% of families under longterm treatment. Another area for research in several programs is prevention by identification of potential abusers. Efforts are under way by questionnaires to pregnant women, analyses of clusters of presumed abusive characteristics, and observations of mother-child interaction on maternity services.

The cost of treatment per case is not recorded at any center except Denver. Estimates made elsewhere were pure guesses; and even in Denver, the range in costs is so great that an average figure would be meaningless. Data were usually available for the sources of salaries for members of the child abuse team, although the dollar amounts were more often withheld. Most of the personnel are paid from county or state funds allocated either to welfare, health, or hospitals. In Denver and Iowa there are state budget line items specifically for the child abuse team personnel; these are the exceptions. More often, people are bootlegged from other duties and responsibilities. Major grants from private foundations have been made to two of the programs. Except for Beaumont, an Army hospital totally supported by the Army, Federal funds are in evidence only through their support of state welfare departments and possibly through the use of Medicaid collections to pay some of the medical costs. (The Los Angeles Children's Hospital program has just received a substantial grant from NIH). The result is widespread uncertainty and apprehension about the stability and continuation of the programs. There is a pervasive desire for hard money to support child abuse activities.

V. CONCLUSION

Under the auspices of the American Academy of Pediatrics, in fulfillment of a contract from the Bureau of Health Services Research and Evaluation, Health Resources Administration, observer teams visited nine programs dealing with child abuse and neglect. A multidisciplinary group of persons with experience in the field consulted on and, to a degree, participated in the site visits. The places visited were deliberately chosen to meet certain criteria: health based, multidisciplinary, widely distributed. They were neither a random nor a representative sample of operating programs. Each visit was completed in a single day, so that the visitors were obliged to rely to a large extent upon the opinions and expressions of the personnel at the various sites. Accordingly, what has emerged is a retailing of the state of the art in these nine centers; their procedures and practices, their problems and coping mechanisms. There can be no across-the-board conclusions concerning the universe of child abuse programs from the observations reported. Nor can general conclusions be drawn concerning incidence, recidivism or success of treatment. Definitions vary; reporting is incomplete; objectives are not clearly stated; follow-up is inadequate. Only comparisons over time within the same programs are likely to have any validity.

Nevertheless, the site visiting teams and the Task Force have been left with a series of impressions which they feel must be taken into consideration as programs are designed or modified in the future.

Child abuse in America is at the point of public outrage at the visible and dramatic end of the spectrum -- the beatings, burnings, and drownings. A punitive approach has been the general rule; and the abusing, yet often loving, parents are fearful and secretive. This pair of attitudes compounds the problems in diagnosis and treatment at both ends of the spectrum. For every severe, identified case there are many less severe which pass through treatment agencies unrecognized, and others not even brought to treatment. Yet, where compassionate treatment programs are known in the community, abusing parents even present themselves for help and find that an accepting, therapeutic, and nonpunitive approach awaits them.

Where there is community education, there seems to be more reporting of child abuse. Where schools are represented on the local child abuse council, there is reporting from the schools. Awareness can be enhanced in a variety of ways. Most of the programs that were visited were giving consideration to this aspect of the problem.

If it is true that the majority of ill and injured children in America are seen by private physicians, and if it is true that child abuse and neglect occur at all socio-economic levels, then many cases are being missed by the private sector. This may be due to a low

index of suspicion, but it was repeatedly asserted that physicians need to be comfortable in reporting and need to know that their patients will be well treated if suspected abuse is reported. Graduate and post-graduate training could be developed to satisfy the first need, but a vast expansion of treatment capacity would be required to satisfy the second.

Along with the hesitancy in reporting suspected abuse, there is difficulty in diagnosis. Many people feel that the use of a team, with a pediatrician, a social worker, and representation of other disciplines, facilitates the acceptance of the responsibility involved in diagnosis, confirmation, and treatment of child abuse. Flexibility in approach should be encouraged, for instance, a mini-team of two or three experienced people -- pediatrician, social worker, psychologist or other -- serving as the nucleus, parttime or on call, of a child abuse team for small communities or small hospitals.

As for limitations on the team, there are at least two principles that come through clearly:

1) A child abuse team cannot deal effectively with a community largerthan about half a million people. Major metropolitan areas should be districted so that one group is not overloaded.

2) The work is so taxing and draining emotionally that no member of the team should be fulltime exclusively in child abuse diagnosis and treatment.

Most programs work under the assumption that children who are in danger in their own homes are safer in foster homes. However, foster homes vary and abuse has also occurred in them. Children do not always do well with foster families; sometimes they may do so for a while, but the benefit may not persist. There is a realization that foster home placement is not a good long-term solution to the problem of child abuse and neglect.

One goal of treatment is to retain, or restore, or create an intact family. Abusing parents can learn not to abuse. For instance, the Denver program has gone several years without a death in its treatment group; and William Beaumont has had no recent deaths from physical abuse in known abusing families, although there have been several in known neglecting families.

Just as team members need respite from the demands of their role, so do parents who have been abusers. There need to be additional resources to allow parents to decompress when tensions are building, before they reach the breaking points. Crisis nurseries, temporary shelters, parent aides, on-call homemakers are some of the modalities that have been used. There does not seem to be one best way.

Consideration of child abuse registries is beyond the scope of this report except insofar as they may facilitate the work of the team. In order to do that, a registry must be accessible at all times. It must have complete and accurate identifying information, not relying on addresses which may change. It should retain a suspected case, even if not confirmed, long enough to match with that child's next medical encounter for treatment of inflicted injury so that the family can be brought under the influence of the child abuse team. Lacking these attributes, a registry may serve a variety of statistical reporting and program purposes; but it will have no immediate clinical utility.

Systematic studies are needed in every phase of child abuse and neglect, including many not in the purview of this survey. The field cries for evaluation, of both process and outcome. The basic question is, "what difference does treatment make?" Are abused children any better off for having been saved from further physical abuse? There are many questions along the way.

The question of effective deployment of coercive state power is in urgent need of study. Similarly, the question of lay involvement in treatment efforts urgently needs empirical exploration.

Traditional psychotherapeutic modalities appear insufficient in child abuse. Psychiatric facilities are not widely enough available to diagnose the 10% or fewer parents who are psychotic and cannot respond to ordinary casework intervention. There is a trend toward lay workers, although problems of selection and training are still unsolved. Is this because they cost less, are more easily available, fit better the abusers' social group? Do they do as good a job, or better?

It is not yet known how to ensure good foster care, or how to evaluate foster homes. What sorts of people provide foster home care? Why? Should foster parents be provided with special training in order to care for abused children? Why do so many children go from foster home to foster home? Can this be changed to provide a continuity of relationships until some arbitrary age? Should additional support -- both financial and social -- be given to foster parents of abused children?

The role and impact of child abuse teams in hospitals and communities should be studied and compared with similar communities without them. How do teams of differing composition vary in their effectiveness and efficiency?

Abusing families appear to need all the friends they can get. The role of community services should be included in any systematic studies. How do they relate to the team? How can communications be improved to the benefit of the children and their parents? Can the

police be trained to take a therapeutic role in child abuse? Are public health nurses brought into the picture appropriately, and to the maximum extent?

Finally, what about efforts at education and prevention? Should child rearing be taught in public schools? Should child abuse prevention and therapy be taught in graduate schools?

Successful elements and basic techniques for the treatment of child abuse have been identified in this study. Additional pilot studies are not needed. It is time for major Federal investments in child abuse treatment and prevention. We can no longer afford to ignore the relationship of child abuse and neglect to society as a whole.

APPENDIX A

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APPENDIX B

CHILD ABUSE SURVEY TASK FORCE

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American Academy of Pediatrics
Pre-survey Questionnaire
HEALTH-BASED FACILITY FOR CHILD ABUSE AND/OR NEGLECT (CA/N)

Name _____

Address _____

_____

Telephone: _____ Director: _____

Date & basis for establishment of CA/N program: _____

_____

FACILITIES

Location of program: _____

Auspices: ☐ Hospital ☐ Medical School ☐ Health Department
☐ Other If other, please explain _____

_____

SOURCE OF FUNDING

	Grant		Other: (state)
	Gov't.	Foundation	
For institution:	_____	_____	_____
For CA/N program:	_____	_____	_____

If grant, what are allotments:

for operation of program? _____ Indirect costs _____

or salaries _____

Review funding restraints _____

_____

_____

Please attach copy of budget.

(Use back of pages or additional sheets, if required)

COMMUNITY CHARACTERISTICS

What are the general demographic characteristics of the Population in the geographic area (state boundaries) surrounding your health facility? Is this the group cared for by the program; or are specific segments of this population served and if so, which? Give percent of referrals that are treated.

_____

_____

_____

_____

PATIENT CHARACTERISTICS AND STATISTICS

	Inpatient	Outpatient
Annual number of pediatric patients:	_____	_____
How many (%) are abused? Can you breakdown abused patients into types and rates of injury? _____	_____	_____
What percent are neglected?	_____	_____
What percent are sexually abused?	_____	_____

Could you handle more patients? _____

What happens when there are more patients than the program can handle?

_____

_____

What information do you collect on your patient population? _____

_____

_____

PATIENT FLOW OR PROCESS

Intake and Identification. State percentage of children who enter the program through the following means:

Emergency Room _____

Child Welfare or Social Service Dept. _____

Neighbor report _____

Other _____

Private Physician _____

Parental call for help _____

Police _____

School _____

Are all children in facility suspected of abuse seen by the team? _____

SERVICES

PERSONNEL: Composition of Child Abuse/Neglect Team in Facility

Name & Job Title	Discipline	Annual Salary	Funding Source	Percent of time on CA/N	Prior Training

Who heads the team? _____

Who acts as Coordinator? _____

Is there ongoing training? _____

Do you hold Case Conferences? _____ Frequency? _____ Who attends? (Enumerate for past 12 months) _____

_____

Are minutes kept? _____

What do personnel in each of the disciplines perceive as the minimum and maximum range of services which should be provided for child abuse and/or neglect?

_____

_____

_____

OPERATING GUIDELINES, GOALS

What are your diagnostic criteria and procedures:

for abused _____

_____

_____

for neglected _____

_____

Are there written goals, guidelines, and procedures? _____ If so, please attach a copy. Are they adhered to? _____ If not, are there unwritten policies? _____ Give examples: _____

_____

Who developed your guidelines? _____

Is there any outreach search via charts or x-ray reviews? _____

_____

Are there any case finding activities other than identification when the child arrives in need of care?

_____

_____

What approaches to the prevention of child abuse and/or neglect are being undertaken by the program or are perceived by the staff as feasible?

_____

_____

TREATMENT/REHABILITATION

Are medical and surgical services available in the hospital on a 24-hour basis? _____

Treatment of the family situation. Does your center provide short-term and long-term rehabilitative services to families? _____ If so, what are they?

_____

_____

_____

If you refer, what arrangements are made? _____

_____

Do you have facilities in your center or the community for evaluation of

/__/ emotional, /__/ learning, /__/ physical disabilities of the children?

PROFILE of ABUSER - Who are suspected or identified abusers and/or neglectors, i.e., parents, siblings, baby sitters. List in order of dominance.

_____

Was the use of either drugs or alcohol suspected or identified as a factor in the abuse? If so, specify which.

_____

WHAT IS RATE OF REPEATED ABUSE for

____single repeaters _____ multiple repeaters

FOLLOW-UP OF CHILD AND FAMILY

What are the mechanics of medical follow-up? _____

_____

Rehabilitation f.u. _____

_____

If return appointments are not kept, what is your procedure?_____

_____

Is there treatment of the family whose child is temporarily placed away from home? Specify.

_____

_____

What attention is paid to siblings of an abused child? _____

_____

If another child is born in the family of an abused child, is there surveillance? _____

If family planning recommended? _____

Criteria for considering home safe: _____

_____

In your experience, how long is the child kept in foster home until his own home is made safe for his return?

_____

_____

Have any changes been documented as a result of follow-up of parents and siblings? _____

_____

Is there systematic review of old cases? _____

What percentage of children and families can you find who were seen one or two years ago? _____

COST OF PATIENT CARE

Average cost of treatment (give ranges) for:

1) Initial entry and evaluation _____ _____

2) Medical-Surgical Treatment _____

3) Rehabilitation _____

If physically handicapping conditions resulted from child abuse and/or neglect, what has been average cost of care? _____

Who pays for services? _____

If cost of services is split between various agencies, delineate: ____

_____

REPORTING

Is reporting mandated by legislation in your state? _____

Is there a Central Registry:

in hospital? _____ in Community? _____

Is Registry:

Effective? _____ Complete? _____ Used? _____

Can CA/ complaint be expunged from Registry? _____ How and by whom? _____

_____

Who makes decision to report? ___ One person _____ Team. If one person, who?)_____

Who transmits report? _____ Who receives it?_____

Reporting procedures nights and weekends?_____

Are parents informed of reporting process?_____

PROTECTIVE MEASURES

Briefly describe relationship of hospital to community facilites as each service affects the operation of the program:

_____

_____

_____

If you wish to hold a child in your hospital, how isthis accomplished?___

_____

_____

Can you retain custody against the parents' wishes? _____

_____

How often is it necessary to hold a child against parents' wishes?_____

_____

DISPOSITION

How is a decision made? _____

_____

What percent are returned to home?_____ to a foster home? _____

Other? _____

What procedures precede final disposition? Conference with family?

_____

_____

COMMUNITY RESOURCES & OUTREACH

What resources are available to the center, i.e.,

_____ Day Care Center. 24 hours? ___ _____Parent Aides

_____ Crisis nursery

_____ Parents Anonymous

_____ Foster homes _____ Hotline

_____Therapeutic foster homes _____ Homemaker

_____Other

Please mark with an asterisk (*) any of above resources contained in your facility.

To what extent would you use these resources if available?_____

_____

Is there a Community Child Abuse Council or Committee? _____

_____

How often does it meet? _____

Makeup? Agencies _____

_____

_____

What is your relation to the

Medical Society:_____ Surgeons_____

Court_____ Public Health Nurses_____

Legal profession _____ Social workers _____

Problems? _____

_____

_____

RESEARCH AND EDUCATION

Do you have continuing education programs in the following schools:

Law _____ Social Work _____

Medical _____ Public Health _____

Nursing _____ Other_____

Are there education programs in-hospital for:

E.R. personnel _____

Nurses _____

Newborn service _____

Predictive questionnaire? Observations? _____

Other _____

OTHER EDUCATION PROGRAMS:

Doctors _____ Police _____

Allied Health Professionals _____ Bar _____

Public Health Nurses _____ Courts _____

Antenatal Classes _____ Lay Groups _____

Mental Health personnel _____ School personnel _____

Media TV, Newspaper, radio _____ Parent effectiveness groups ____

Other _____

What would you do to expand your program? _____

_____

_____

What research are you doing?

_____

_____

_____

What do you consider problems that interfere with the full development of the program you would want?

_____

_____